DOCUMENT RESUME

ED 226 238 CE 035 200

TITLE	Psychiatry Ward Specialist, 10-12. Military Curriculum Materials for Vocational and Technical Education.
INSTITUTION	Air Force Training Command, Sheppard AFB, Tex.; Ohio State Univ., Columbus. National Center for Research in Vocational Education.
SPONS AGENCY	Office of Education (DHEW), Washington, D.C.
PUB DATE	78
NOTE	369p.; For related documents see CE 035 301-302.
PUB TYPE	Guides - Classroom Use - Guides (For Teachers) (052) -- Guides - Classroom Use - Materials (For Learner) (051)
EDRS PRICE	MF01/PC15 Plus Postage.
DESCRIPTORS	Behavioral Objectives; Lesson Plans; *Mental Disorders; Mental Health Programs; Military Training; *Nursing Education; Postsecondary Education; Programed Instructional Materials; *Psychiatric Aides; *Psychiatric Services; Psychiatry; *Teaching Methods; *Units of Study; Workbooks
IDENTIFIERS	Military Curriculum Project

ABSTRACT

This course, adapted from military curriculum materials for use in vocational and technical education, is designed to train students to perform as assistants to professional personnel in the care and treatment of patients in mental health units. It includes basic concepts of human behavior, the aspects of atypical adjustive reactions, the importance of behavior observations, and the need for nursing intervention. (Medical Service Specialist 10-11 is a prerequisite course.) The course is divided into two blocks of instruction covering 43 hours. Block 1 contains 12 lessons on basic concepts of mental health and mental illness, while block 2 contains both teacher and student materials. Printed instructor materials include a course chart and a plan of instruction detailing the units of instruction, criterion objectives, the duration of the lessons, and support materials needed. Printed student materials include 9 study guide/workbooks and 4 programmed texts for block 1 and 15 study guide/workbooks and 2 programmed texts for block 2. The course is designed for group instruction. (KC)

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MILITARY CURRICULUM MATERIALS

The military-developed curriculum materials in this course package were selected by the National Center for Research in Vocational Education Military Curriculum Project for dissemination to the six regional Curriculum Coordination Centers and other instructional materials agencies. The purpose of disseminating these courses was to make curriculum materials developed by the military more accessible to vocational educators in the civilian setting.

The course materials were acquired, evaluated by project staff and practitioners in the field, and prepared for dissemination. Materials which were specific to the military were deleted, copyrighted materials were either omitted or approval for their use was obtained. These course packages contain curriculum resource materials which can be adapted to support vocational instruction and curriculum development.

The National Center Mission Statement

The National Center for Research in Vocational Education's mission is to increase the ability of diverse agencies, institutions, and organizations to solve educational problems relating to individual career planning, preparation, and progression. The National Center fulfills its mission by:

- Generating knowledge through research
- Developing educational programs and products
- Evaluating individual program needs and outcomes
- Installing educational programs and products
- Operating information systems and services
- Conducting leadership development and training programs

FOR FURTHER INFORMATION ABOUT
Military Curriculum Materials
WRITE OR CALL
Program Information Office
The National Center for Research in Vocational Education
The Ohio State University
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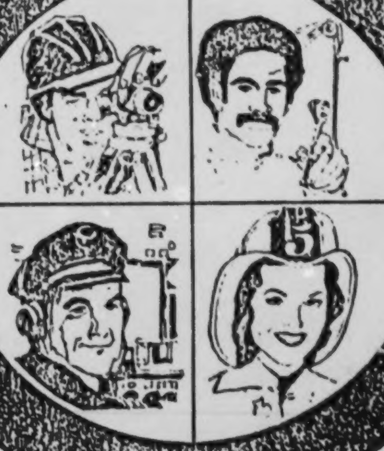
Military Curriculum Materials for Vocational and Technical Education

Information and Field
Services Division

The National Center for Research
in Vocational Education



Military Curriculum Materials Dissemination Is . . .

an activity to increase the accessibility of military-developed curriculum materials to vocational and technical educators.

This project, funded by the U.S. Office of Education, includes the identification and acquisition of curriculum materials in print form from the Coast Guard, Air Force, Army, Marine Corps and Navy.

Access to military curriculum materials is provided through a "Joint Memorandum of Understanding" between the U.S. Office of Education and the Department of Defense.

The acquired materials are reviewed by staff and subject matter specialists, and courses deemed applicable to vocational and technical education are selected for dissemination.

The National Center for Research in Vocational Education is the U.S. Office of Education's designated representative to acquire the materials and conduct the project activities.

Project Staff:

Wesley E. Budke, Ph.D., Director
National Center Clearinghouse

Shirley A. Chase, Ph.D.
Project Director

What Materials Are Available?

One hundred twenty courses on microfiche (thirteen in paper form) and descriptions of each have been provided to the vocational Curriculum Coordination Centers and other instructional materials agencies for dissemination.

Course materials include programmed instruction, curriculum outlines, instructor guides, student workbooks and technical manuals.

The 120 courses represent the following sixteen vocational subject areas:

- Agriculture
- Aviation
- Building & Construction Trades
- Clerical Occupations
- Communications
- Drafting
- Electronics
- Engine Mechanics
- Food Service
- Health
- Heating & Air Conditioning
- Machine Shop
- Management & Supervision
- Meteorology & Navigation
- Photography
- Public Service

The number of courses and the subject areas represented will expand as additional materials with application to vocational and technical education are identified and selected for dissemination.

How Can These Materials Be Obtained?

Contact the Curriculum Coordination Center in your region for information on obtaining materials (e.g., availability and cost). They will respond to your request directly or refer you to an instructional materials agency closer to you.

CURRICULUM COORDINATION CENTERS

EAST CENTRAL
Rebecca S. Douglass
Director
100 North First Street
Springfield, IL 62777
217/782-0759

MIDWEST
Robert Patton
Director
1515 West Sixth Ave.
Stillwater, OK 74704
405/377-2000

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Joseph F. Kelly, Ph.D.
Director
225 West State Street
Trenton, NJ 08625
609/292-6562

NORTHWEST
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SOUTHEAST
James F. Shill, Ph.D.
Director
Mississippi State University
Drawer DX
Mississippi State, MS 39762
601/325-2510

WESTERN
Lawrence F. H. Zane, Ph.D.
Director
1776 University Ave.
Honolulu, HI 96822
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PSYCHIATRY WARD SPECIALIST **Classroom Course** **10-12**

Developed by:

United States Air Force

Development and Review Dates:

July 25, 1975

D.O.T. No.:

079.378

Occupational Area:

Health

Target Audiences:

Grades 13-adult

Print Pages:

337

Cost:

Availability:

Military Curriculum Project, The Center for Vocational Education, 1960 Kenny Rd., Columbus, OH 43210

Contents:	Type of Materials: Lesson Plans:	Programmed Text:	Student Workbook:	Handouts:	Text Materials:	Audio-Visuals:	Instructional Design: Performance Objectives:	Tests:	Review Exercises:	Additional Materials Required:	Type of Instruction: Group Instruction:	Individualized:	
			No. of pages										
Block I – *Basic Concepts of Mental Health and Mental Illness*	●	●	83		●	★	●	★	●	★	●		
Block II – *Care and Treatment of the Mentally Ill*	●	●	141		●	★	●	★		★	●		

★ **Materials are recommended but not provided.**

THE CENTER FOR VOCATIONAL EDUCATION
THE OHIO STATE UNIVERSITY

Expires July 1, 1978

Course Description

This course is designed to train students to perform as assistants to professional personnel in the care and treatment of patients in mental health units. It includes basic concepts of human behavior, the aspects of atypical adjustive reactions and the importance of behavior observations, and the need for nursing intervention. **Medical Service Specialist**, (10-11) is a prerequisite course.

The course is divided into two blocks of instruction and one block of practical experience. The block on practical experience was deleted because it discusses specific military programs and contains little printed matter. The remaining two blocks cover 43 hours of instruction.

Block I — *Basic Concepts of Mental Health and Mental Illness* contains twelve lessons covering 17 hours of instruction. The orientation lesson was deleted. Lesson topics and respective hours follow:

Legal and Moral Aspects (1 hour)
Introduction to Mental Health Nursing (1 hour)
Duties of Psychiatric Ward Specialist (1.5 hours)
Terminology (1.5 hours)
Normal Needs of Patients (1 hour)
Stages of Personality Development (2 hours)
Adjustive Reactions and Motivation and Perception (2 hours)
Predisposing and Precipitating Factors ([illegible] hour)
Communication (1 hour)
Principles of Mental Health Nursing (2 hours)
Recording Observations (1 hour)
Therapeutic Environment and the Psychiatric Team (2 hours)

Block III — *Care and Treatment of the Mentally Ill* contains fifteen lessons covering 26 hours of instruction.

Protective Measures (1 hour)
Restraints (1 hour)
Chemotherapy (2 hours)
Special Therapies (1 hour)
Psychotherapy (2 hours)
Nursing Care and Approaches - Anxiety (3 hours)
Theory of Schizophrenia (2 hours)
Nursing Care and Approaches - Withdrawal (2 hours)
The Suspicious Patient (1.5 hours)
Depression (1 hour)
Suicidal Patient (1.5 hours)
Nursing Care and Approaches - Excited Patient, Patient Who Acts Out, and Alcoholics and Drug Addicts (4.5 hours)
Chronic Mental Illness (1.5 hours)
Admitting Mentally Ill (1 hour)
Rehabilitation Resources (1 hour)

This course contains both teacher and student materials. Printed instructor materials include a course chart and a plan of instruction detailing the units of instruction, criterion objectives, the duration of the lessons, and support materials needed. Printed student materials include nine study guide/workbooks and four programmed texts for Block I and fifteen study guide/workbooks and two programmed texts for Block II.

Several commercially produced texts are referenced as support material. Audiovisual aids suggested for use in the course include 12 films, 7 sound slide programs, 5 videotapes, and 1 audio tape.

PSYCHIATRY WARD SPECIALIST

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Restraints - Study Guide Page 183

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Chronic Mental Illness - Study Guide & Workbook Page 311

Admitting The Mental Health Patient - Handout Page 314

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POI 3ABR91431-2
(PDS Code Q76)

PLAN OF INSTRUCTION
(Technical Training)

PSYCHIATRIC WARD SPECIALIST

10-12
Block I

AIR TRAINING COMMAND

SHEPPARD TECHNICAL TRAINING CENTER

25 July 1975 - Effective 12 September with Class 750731

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LIST OF CURRENT PAGES

This POI consists of 26 current pages issued as follows:

Page No.	Issue
Title	Original
A	Original
i	Original
1 thru 23	Original

DISTRIBUTION: AFMPC/SGE-2; ATC/SGHE-2; AUL-1; CCAF/AY-2; Sheppard: SGPM/200-1; MSOR-1; MSOXC-11; MSDN-25.

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PLAN OF INSTRUCTION

COURSE TITLE Psychiatric Ward Specialist

BLOCK TITLE Basic Concepts of Mental Health and Mental Illness

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
NOTE: For objectives in this POI which are knowledge-oriented and do not develop a skill, items on the written tests for the course will serve as the required standard and condition.		
1. Welcome and Orientation a. Course welcome, course content, and administration b. Safety in the training environment c. Course and school policies d. Types and uses of course instructional materials e. Student critique program f. Energy conservation g. Effective study procedures h. Community College of the Air Force (CCAF) briefing i. Fire Safety	1	Column 1 Reference None STS Reference None Instructional Materials SW 3ABR91431-2-I-1, Introduction to the Psychiatric Ward Specialist Course McClelland, Textbook for Psychiatric Technicians American Psychiatric Association, Psychiatric Glossary SKF Laboratories, Psychiatric Nurse's Guide to Tranquilizing Drugs Personal Data Sheets Student Information Sheets Training Methods Discussion (1 hr) Instructional Environment/Design Classroom (1 hr) Group/Lock Step Instructional Guidance Issue SW's for Blocks I and II and PT to students. Textbooks, glossary and black plastic folders, personal data sheets, and student information sheet will be issued at this time also. Personal data sheet and student information sheet must be completed by the students and returned to the instructor for filing. Students will be provided information regarding chain of command, evaluation procedures, Honor Graduate Program, counseling and assistance, individualized assistance, class leader, absence from

PLAN OF INSTRUCTION NO. 3ABR91431-2	DATE 25 JUL 1975	BLOCK NO. I	PAGE NO. 1

PLAN OF INSTRUCTION (Continued)

1 UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
		class, break schedules, personal appearance, complaints, and enrollment forms.
2. Legal and Moral Aspects a. State the basic concepts of legal and moral aspects of mental health nursing.	1	Column 1 Reference 2a — STS Reference 5a, 5b, 5c, 12c(1), 12c(2) Instructional Materials SW 3ABR91431-2-I-2, Legal and Moral Aspects Manfreda, Psychiatric Nursing Training Methods Discussion (1 hr) Instructional Environment/Design Classroom (1 hr) Group/Lock Step
3. Introduction to Mental Health Nursing a. Describe the characteristics and aims of USAF mental health nursing.	1	Column 1 Reference 3a — STS Reference 12c(1) Instructional Materials WB 3ABR91431-2-I-3, Introduction to Mental Health Nursing Manfreda, Psychiatric Nursing Audio Visual Aids Sound-on-slide, Introduction to Mental Health Nursing (1 hr) Training Methods Performance (1 hr) Instructional Environment/Design Learning Resource Center (1 hr) Group/Lock Step Instructional Guidance Students will review Sound-on-slide in LRC, then complete WB 3ABR91431-2-I-3a.

LAN OF INSTRUCTION NO. 3ABR91431-2	DATE 25 JUL 1975	BLOCK NO. I	PAGE NO 2

1 UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
4. Duties of the Psychiatric Ward Specialist a. Select the duties of the Psychiatric Ward Specialist in the career ladder progression.	1.5	Column 1 Reference 4a STS Reference 1a, 1b, 1c(1), 1c(2), 12c(1), 12c(2), 13b(3) Instructional Materials SW 3ABR91431-2-I-4, Duties of the Psychiatric Ward Specialist AFM 35-1, Military Personnel Classification Policy AFM 39-1, Airman Classification Manual Audio Visual Aids Film, TF 5963, Atmosphere for Therapy (22 min) Training Methods Discussion (1.5 hr) Instructional Environment/Design Classroom (1.5 hr) Group/Lock Step Instructional Guidance Student will view film in the classroom
5. Terminology a. Define common terminology in current use in mental health nursing.	1.5	Column 1 Reference 5a STS Reference 9a Instructional Materials PT 3ABR91431-2-I-5, Terminology American Psychiatric Association, A Psychiatric Glossary McClelland, Textbook for Psychiatric Technicians Hinsie and Campbell, Psychiatric Dictionary Training Methods Discussion (1 hr) Performance (.5 hr) Instructional Environment/Design Classroom (1 hr) Laboratory (.5 hr) Group/Lock Step

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Instructional Guidance Have students complete Programmed Text followed by discussion. Administer a quiz on terminology the last part of class.
6. Normal Needs of Patients a. Describe the normal needs of psychiatric patients.	1	Column 1 Reference: 6a STS Reference: 9e, 9f(1), 9f(2), 12b(1), 12b(2), 12b(3), 12b(4), 12c(6) Instructional Materials PT 3ABR91431-2-I-4, Normal Needs of Patients Audio Visual Aids Film, FLC 23-105, Who Cares About Jamie (16 min) Training Methods Discussion (0.8 hrs) Performance (0.2 hrs) Instructional Environment/Design Classroom (0.8 hrs) Laboratory (0.2 hrs) Group/Lock Step Instructional Guidance After viewing the film, discuss aspects of needs of the patient. Have students complete PT after discussion.
7. Stages of Personality Development a. Describe the structures and stages of personality development. b. Explain the relationship of heredity and environment and its effects on the personality.	3 (2/1)	Column 1 Reference: 7a — STS Reference: 9b(1), 9b(2) Column 1 Reference: 7b — STS Reference: 9b(2) Instructional Materials SG 3ABR91431-2-I-7a, Stages of Personality Development WB 3ABR91431-2-I-7b, Heredity and Environment Manfreda, Psychiatric Nursing Coleman, Abnormal Psychology and Modern Life McClelland, Textbook for Psychiatric Technicians

1 UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
		Audio Visual Aids Sound-on-slide, Heredity and Environment (30 min) Training Methods Discussion (1 hr) Performance (1 hr) Outside Assignments (1 hr) Instructional Environment/Design Classroom (1 hr) Learning Resources Center (1 hr) Home Study (1 hr) Group/Lock Step Instructional Guidance WB 3ABR91431-2-I-7b will be completed in the LRC. SW 3ABR91431-2-I-7a will be completed outside of class and a check on that material will be administered in class.
8. Adjustive Reactions and Motivation and Perception a. Describe adjustive reactions and their effects on behavior. b. Explain the general principles and relationship of motivation and perception to behavior.	3 (2/1)	Column 1 Reference — STS Reference 8a — 9c, 12a(1) 8b — 12a(1) Instructional Materials PT 3ABR91431-2-I-8a, Adjustive Reactions SW 3ABR91431-2-I-8b, Motivation and Perception Coleman, Abnormal Psychology and Modern Life Audio Visual Aids Film, SFP 1844, Eye of the Beholder (29 min) Training Methods Discussion (2 hrs) Outside Assignments (1 hr) Instructional Environment/Design Classroom (2 hrs)

PLAN OF INSTRUCTION (Continued)

1. UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
		Home Study (1 hr) Group/Lock Step Instructional Guidance Students will view film and discuss motivation and perception. PT will be completed as home study and SG will be reviewed for outside assignment, with exercises performed under instructor supervision. After discussion of both criterion objectives, a quiz will be given on the subject matter for this unit.
9. Predisposing and Precipitating Factors a. State the principles of predisposing and recipitating factors in mental health.	1	Column 1 Reference: 9a STS Reference: 9g, 12a(2) Instructional Materials SW 3ABR91431-2-I-9, Predisposing and Precipitating Factors Coleman, Abnormal Psychology and Modern Life Audio Visual Aids Sound-on-slide, Predisposing and Precipitating Factors (30 min) Training Methods Discussion (.2 hr) Performance (.8 hr) Instructional Environment/Design Classroom (.2 hr) Learning Resource Center (.8 hr) Group/Lock Step Instructional Guidance After completion of sound-on-slide viewing in LRC, take students back to classroom for discussion and assignments for next day.
10. Communication a. State the principles and factors affecting communication as it applies to mental health nursing.	1	Column 1 Reference: 10a STS Reference: 9d(1), 9d(2), 9d(3), 9d(4), 12a(2) Instructional Materials WB 3ABR91431-2-I-10, Communication

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
this instructional program is a combination audio visual presentation & workbook. audio visual aids are not available through this project.		McClelland, Textbook for Psychiatric Technicians Mathaney and Topalis, Psychiatric Nursing Audio Visual Aids Sound-on-slid, Communication (30 min) Training Methods Performance (1 hr) Instructional Environment/Design Laboratory (.2 hr) Learning Resource Center (.8 hr) Group/Lock Step Instructional Guidance Have students report to the LRC and accomplish the sound-on-slide and WB. After program is completed, they will return to class and participate in a communication game to emphasize the importance and necessity of effective communication.
11. Principles of Mental Health Nursing a. Explain the principles of mental health nursing as it affects patients, family, and staff.	4 (2/2)	Column 1 Reference: 11a STS Reference: 9d(2), 9d(3), 9d(4), 11a(1), 11a(2), 11a(3) Instructional Materials PT 3ABR91431-2-I-11, Principles of Mental Health Nursing McClelland, Textbook for Psychiatric Technicians Travelbee, Intervention in Psychiatric Nursing Mathaney and Topalis, Psychiatric Nursing Roche Drug Company, Let Your Light So Shine Audio Visual Aids Film, FLC 16-178, Psychiatric Nursing - Nurse-Patient Relationship (34 min) Training Methods Discussion (2 hrs) Outside Assignments (2 hrs)

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3ABR91431-2	25 JUL 1975	I	7

PLAN OF INSTRUCTION (Continued)

1 UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
		Instructional Environment/Design Classroom (2 hrs) Home Study (2 hrs) Group/Lock Step Instructional Guidance Students will view film in the classroom and participate in discussion of principles of MHN. A quiz will be administered after the discussion. PT is accomplished as home study.
12. Recording Observations a. State the principles and techniques of recording observations.	1	Column 1 Reference 12a STS Reference 12d, 13d(2) Instructional Materials WB 3ABR91431-2-I-12, Recording Observations McClelland, Textbook for Psychiatric Technicians Mathaney and Topalis, Psychiatric Nursing Audio Visual Aids Videotape, CDN-13, Principles of Recording Observations (30 min) Training Methods Discussion (.5 hr) Performance (.5 hr) Instructional Environment/Design Classroom (.5 hr) Learning Resource Center (.5 hr) Group/Lock Step Instructional Guidance Students report to LRC for videotape presentation and then return to class for further discussion of subject matter. WB is accomplished in the LRC.
13. Therapeutic Environment and the Psychiatric Team	2	Column 1 Reference 13a 13b STS Reference 11b(1), 11b(2) 1c(1), 1c(2), 12d, 13e

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION/OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
a. Describe the characteristics of a mental health unit which creates a therapeutic environment. b. State the purpose and duties of the psychiatric team.		Instructional Materials SW 3ABR91431-2-I-13, Therapeutic Environment and the Psychiatric Team McClelland, *Textbook for Psychiatric Technicians* Mathaney and Topalis, *Psychiatric Nursing* Noyes, Camp and Van Sickel, *Psychiatric Nursing* Kolb, *Modern Clinical Psychiatry* Audio Visual Aids Film, FLV 16-138, People Who Care (25 min) Training Methods Discussion (1.5 hrs) Performance (.5 hr) Instructional Environment/Design Classroom (1.5 hrs) Laboratory (.5 hr) Group/Lock Step Instructional Guidance After viewing film, students will complete SW exercises.
14. Measurement Test and Test Critique a. Measurement Test b. Test Critique	2	

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PLAN OF INSTRUCTION	COURSE TITLE Psychiatric Ward Specialist
BLOCK TITLE Care and Treatment of the Mentally Ill	

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
1. Protective Measures a. After a review of the purposes and methods of protective measures, correctly apply five of the manual holds on a simulated patient, as illustrated in SW 3ABR91431-2-II-1.	2 (1/1)	Column 1 Reference: 1a STS Reference: 4b, 4d(1), 12c(1) Instructional Materials SW 3ABR91431-2-II-1, Protective Measures Audio Visual Aids Film 160-661, Protective Measures (15 min) Training Methods Discussion (.3 hr) Demonstration (.2 hr) Performance (.5 hr) Outside Assignments (1 hr) Instructional Environment/Design Classroom (.3 hr) Laboratory (.7 hr) Home Study (1 hr) Group/Lock Step Instructional Guidance Ensure that the entire class has read SW 3ABR91431-2-I-1 before proceeding to view film, "Protective Measures". After the film, have students group into pairs to practice manual holds.
2. Restraints a. After discussion and demonstration of procedures for application of restraints on a hyperactive patient, apply restraints to a simulated patient as prescribed in SG 3ABR91431-2-II-2. Student must correctly accomplish all	1	Column 1 Reference: 2a STS Reference: 4b, 4d(2), 13c(3) Instructional Materials SG 3ABR91431-2-II-2, Restraints

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
steps on the checklist 3ABR91431-2-II-2a.		**Audio Visual Aids** Videotape, CDN-1, Restraints (12 min) **Training Equipment** Hospital beds (1) Restraints set (2) Restraint key (2) Litter (1) **Training Methods** Discussion (.3 hr) Demonstration (.2 hr) Performance (.5 hr) **Instructional Environment/Design** Learning Resource Center (.3 hr) Laboratory (.7 hr) Group/Lock Step **Instructional Guidance** Students will be criterion checked for proper application of restraints. Insure safety of students while applying restraints to one another.
3. Chemotherapy a. Specify the therapeutic action and side reaction of commonly used drugs in psychiatric treatment.	3 (2/1)	**Column 1 Reference** 3a **STS Reference** 4b, 12e(7)(a), 12e(7)(b), 12e(7)(c)1, 12e(7)(c)2, 12e(7)(c)3, 12e(7)(c)4 **Instructional Materials** WB 3ABR91431-2-II-3, Chemotherapy Musser and Shubkogel, Pharmacology and Therapeutics Smith, Kline, and French, Psychiatric Nursing Guide to Therapy Physicians' Desk Reference and Formulary **Audio Visual Aids** Sound-on-slide, Chemotherapy (30 min) **Training Methods** Discussion (1.4 hrs)

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Performance (.6 hr) Outside Assignments (1 hr) __Instructional Environment/Design__ Classroom (1.4 hrs) Learning Resource Center (.6 hr) Home Study (1 hr) Group/Lock Step __Instructional Guidance__ Students will begin class in LRC for sound-on-slide presentation. After returning to classroom for discussion, administer the quiz. Make outside assignments for the next day near the end of the hour.
4. __Special Therapies__ a. Define the different therapies and their functions as utilized in psychiatric treatment.	1	__Column 1 Reference__ 4a __STS Reference__ 12e(2), 12e(3), 12e(4), 12e(5) __Instructional Materials__ WB 3ABR91431-2-II-4, Special Therapies McClelland, __Textbook for Psychiatric Technicians__ Manfreda, __Psychiatric Nursing__ Fidler, __Psychiatric Occupational Therapy__ __Audio Visual Aids__ Sound-on-slide, Special Therapies (20 min) Videotape, CDN-2, Electroconvulsive Treatment (10 min) __Training Methods__ Discussion (.6 hr) Performance (.4 hr) __Instructional Environment/Design__ Classroom (.6 hr) Learning Resource Center (.4 hr) Group/Lock Step __Instructional Guidance__ Students report to Learning Resource Center for Videotape and

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Sound-on-slide presentations and then return to class for further discussion of subject matter. Check WB for accuracy.
5. Psychotherapy a. Identify the principles of psychotherapy and its role in psychiatric rehabilitation.	3 (2/1)	Column 1 Reference: 5a STS Reference: 12e(1), 12e(6) Instructional Materials SW 3ABR91431-2-II-5, Psychotherapy Coleman, Abnormal Psychology and Modern Life Johnson, Group Therapy: A Practical Approach McClelland, Textbook for Psychiatric Technicians Audio Visual Aids Videotape, CDN-5, Dynamics of Change (45 min) Training Methods Discussion (2 hrs) Outside Assignments (1 hr) Instructional Environment/Design Classroom (1 hr) Learning Resource Center (1 hr) Home Study (1 hr) Group/Lock Step Instructional Guidance Students will view videotape and have a discussion of subject matter while in LRC. After break, students will return to classroom for discussion of Group Therapy.
6. Nursing Care and Approaches - Anxiety a. Identify the patterns of patients displaying anxiety. b. Given a case study on the anxious patient, design a plan of care which will identify the patient's problems and needs, and the	4 (3/1)	Column 1 Reference / STS Reference 6a: 12b(1), 12b(2), 12b(3) 6b: 8a(3), 12b(1), 12b(2), 12b(3), 13b(3), 13d(2) Instructional Materials PT 3ABR91431-2-II-6, Nursing Care and Approaches - Anxiety Case Study Handout

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
appropriate nursing approaches necessary to cope with these problems. A minimum of 8 problems and needs must be correctly identified.		Rowe, An Outline of Psychiatry Coleman, Abnormal Psychology and Modern Life Crawford, Psychiatric Nursing: A Basic Manual **Audio Visual Aids** Audio Tape, Mental Hygiene (1 hr) **Training Methods** Discussion (1.5 hrs) Performance (1.5 hrs) Outside Assignments (1 hr) **Instructional Environment/Design** Classroom (1.5 hrs) Laboratory (1.5 hrs) Home Study (1 hr) Group/Lock Step **Instructional Guidance** After reviewing the audio tape, administer students a quiz on the anxious patient. The PT will be completed outside of class. A case study will be handed out and a plan of care will be written and used in role playing. Make assignments for next day at end of class.
7. Theory of Schizophrenia a. Identify the different types of schizophrenia and the behavior patterns manifested by each type.	3 (2/1)	**Column 1 Reference** 7a **STS Reference** 9a, 12a(9) **Instructional Materials** SW 3ABR91431-2-II-7, Theory of Schizophrenia Coleman, Abnormal Psychology and Modern Life McClelland, Textbook for Psychiatric Technicians **Audio Visual Aids** Film, FLC 19-226, Schizophrenia: The Shattered Mirror (1 hr) **Training Methods** Discussion (2 hrs) Outside Assignments (1 hr)

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Instructional Environment/Design Classroom (2 hrs) Home Study (1 hr) Group/Lock Step Instructional Guidance After viewing film and discussing the theory of schizophrenia, administer a quiz.
8. Nursing Care and Approaches - Withdrawal a. Identify the correct nursing care and approaches for the withdrawn patient.	1	Column 1 Reference: 8a STS Reference: 12b(1), 12b(2), 12b(3), 12c(6) Instructional Materials SW 3ABR91431-2-II-8, Nursing Care and Approaches - Withdrawal Mathaney and Topalis, Psychiatric Nursing Crawford, Psychiatric Nursing Chapman, Management of Emotional Disorders Audio Visual Aids None Training Methods Discussion (1 hr) Instructional Environment/Design Classroom (1 hr) Group/Lock Step Instructional Guidance SW will be completed in class and checked for accuracy.
9. The Suspicious Patient a. Identify the behavior patterns of the suspicious patient.	1.5	Column 1 Reference: 9a, 9b STS Reference: 12a(3), 12b(1), 12(2), 12b(3)

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
b. Describe appropriate nursing care and approaches for a suspicious patient.		Instructional Materials SW 3ABR91431-2-II-9, The Suspicious Patient Manfreda, Psychiatric Nursing McClelland, Textbook for Psychiatric Technicians Audio Visual Aids Film, MN 9778C, Mental Health and Military Effectiveness - It's A Plot (43 min) Training Methods Discussion (1 hr) Performance (.5 hr) Instructional Environment/Design Classroom (1 hr) Laboratory (.5 hr) Group/Lock Step Instructional Guidance After viewing film, have students complete workbook.
10. Depression a. Describe the nursing care and approaches for the behavior patterns of a depressed patient.	1	Column 1 Reference 10a STS Reference 12a(4), 12b(1), 12b(2), 12b(3), 12c(6) Instructional Materials WB 3ABR91431-2-II-10, Depression Chapman, Management of Emotional Disorders McClelland, Textbook for Psychiatric Technicians Audio Visual Aids Sound-on-slide, Depression (30 min) Video cassette, CDM 66, I Want to Die (30 min) Training Methods Performance (1 hr) Instructional Environment/Design Learning Resource Center (1 hr) Group/Lock Step

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Instructional Guidance WB will be completed in the LRC
11. Suicidal Patient a. State the signs and symptoms of a suicide patient.	2.5 (1.5/1)	Column 1 Reference 11a — STS Reference 12b(1), 12b(2), 12b(3), 12c(2) Instructional Materials SW 3ABR91431-2-II-11, Suicidal Patient Chapman, Management of Emotional Disorders Audio Visual Aids Film, TF 8-3968, Suicide--The Unheard Cry (45 min) Training Methods Discussion (1.5 hrs) Outside Assignments (1 hr) Instructional Environment/Design Classroom (1.5 hrs) Home Study (1 hr) Group/Lock Step Instructional Guidance After reviewing film in classroom and discussion, administer a quiz. Give assignments for tomorrow's classes.
12. Nursing Care and Approaches - Excited Patient, Patient Who Acts Out and Alcoholics and Drug Addicts a. Describe the behavior patterns of the excited patient. b. State the behavior patterns of the patient who acts out his anxiety.	4.5	Column 1 Reference — STS Reference 12a — 12a(7), 12b(1), 12b(2), 12c(6) 12b — 12a(8) 12c — 12a(5), 12a(6), 12b(3), 12c(5) Instructional Materials SW 3ABR91431-2-II-12a, Nursing Care and Approaches - Excited Patient SW 3ABR91431-2-II-12b, Nursing Care and Approaches for the Patient Who Acts Out SW 3ABR91431-2-II-12c, Nursing Care and Approaches for the Alcoholic and the Drug Addict

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PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
c. Describe the problems and needs of the drug addict and alcoholic, and the approaches used to meet these needs.		Crawford, Psychiatric Nursing: A Basic Manual Manfreda, Psychiatric Nursing Coleman, Abnormal Psychology and Modern Life Chapman, Management of Emotional Disorders McClelland, Textbook for Psychiatric Technicians Roche, Pharmaceutical Company, Aspects of Alcoholism Pamphlet, Drug Abuse A Game Without Winners, (Armed Force Information Services) AFM 35-4, Issue and Control of Meal Cards AFM 168-4, Administration of Medical Activities VA Pamphlet 23-67-1, Vocational Rehabilitation and Other Benefits Information Audio Visual Aids Film, MN 9778B, Mental Health and Military Effectiveness--The Man Child (40 min) Training Methods Discussion (4.5 hrs) Instructional Environment/Design Classroom (4.5 hrs) Group/Lock Step
13. Chronic Mental Illness a. Identify the behavior patterns of mentally ill persons who are chronically ill.	3.5 (1.5/2)	Column 1 Reference: 13a STS Reference: 12a(2), 12b(1), 12b(2), 12b(3) Instructional Materials SW 3ABR91431-2-II-13, Chronic Mental Illness McClelland, Textbook for Psychiatric Technicians Manfreda, Psychiatric Nursing Mathaney and Topalis, Psychiatric Nursing (5th Ed.) Audio Visual Aids Film, FLC 20-133, Ninety-First Day (The) (92 min)

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
		Training Methods Discussion (1.5 hrs) Outside Assignments (2 hrs) Instructional Environment/Design Classroom (1.5 hrs) Home Study (2 hrs) Group/Lock Step Instructional Guidance The class will view the film, The 91st Day, discuss the material, and check completeness of workbook.
14. Admitting Mentally Ill a. After a review and discussion of the procedures used in admitting mental health patients, demonstrate by role playing the appropriate procedures for admitting a mental health patient. Students must perform 80 percent of the procedures on the checklist 3ABR91431-2-II-14a.	2 (1/1)	Column 1 Reference: 14a STS Reference: 12c(3), 12c(4), 13c(1), 13d(1), 13d(4) Instructional Materials HO 3ABR91431-2-II-14, Admitting the Mental Health Patient McClelland, Textbook for Psychiatric Technicians Manfreda, Psychiatric Nursing Audio Visual Aids Film, TVS 91-1, Admitting the Mentally Ill Patient (15 min) Training Equipment Clinical Thermometer (2) Sphygmomanometer (2) Scales (1) Stethoscopes (2) Training Methods Discussion (.5 hr) Performance (.5 hr) Outside Assignments (1 hr) Instructional Environment/Design Classroom (.5 hr) Laboratory (.5 hr)

PLAN OF INSTRUCTION (Continued)

1 UNITS OF INSTRUCTION AND CRITERION OBJECTIVES	2 DURATION (HOURS)	3 SUPPORT MATERIALS AND GUIDANCE
		Home Study (1 hr) Group/Lock Step
15. Rehabilitation Resources a. Describe the community resources used in rehabilitating mental health patients.	2 (1/1)	Column 1 Reference: 15a STS Reference: 10a, 10b, 10c, 10d, 12a(5), 12a(6) Instructional Materials PT 3ABR91431-2-II-15, Rehabilitation Resources Chapman, Management of Emotional Disorders Manfreda, Psychiatric Nursing VA Pamphlet 23-67-1, Vocational Rehabilitation and Other Benefits Information Training Methods Discussion (.5 hr) Performance (.5 hr) Outside Assignments (1 hr) Instructional Environment/Design Classroom (.5 hr) Laboratory (.5 hr) Home Study (1 hr) Group/Lock Step Instructional Guidance Students will accomplish Programmed Text followed by discussion.
16. Measurement Test and Test Critique a. Measurement Test b. Test Critique	2	

PLAN OF INSTRUCTION NO. 3ABR91431-2	DATE 25 JUL 1976	BLOCK NO. II	PAGE NO. 20

PLAN OF INSTRUCTION	COURSE TITLE Psychiatric Ward Specialist	
BLOCK TITLE Practical Application of Principles of Mental Health Nursing		
UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
1. Orientation to USAF Regional Hospital Sheppard AFB, Texas, Mental Health Unit a. Physical plan of mental health service units. b. Functions of the mental health service units. c. Personnel within the mental health service. d. Student responsibilities during hospital experience.	1	Instructional Materials SG 3ABR91431-2-III-1, Orientation to USAF Regional Hospital, SAFB, Texas Mental Health Unit Training Methods Discussion (.5 hr) Demonstration (.5 hr) Instructional Environment/Design Classroom (.5 hr) Laboratory (.5 hr) Group/Lock Step Instructional Guidance The instructor presents orientation to Sheppard AFB hospital, then accompanies the class to the hospital to familiarize them with the mental health wards.
2. Planning and Giving Care to Mental Health Patients a. At the hospital, under the supervision of an instructor, apply principles of mental health nursing as they relate to the role of the Psychiatric Ward Specialist by writing interaction notes on an assigned patient's activities. Accuracy of 80 percent of checklist 3ABR91431-2-III-2a items is required.	133 (101/32) (11)	Column 1 Reference — STS Reference 2a — 5a, 8a(3), 12b(1), 12b(2), 13d(2) 2b — 5a, 5b, 8a(3), 12b(1), 12b(2), 12c(6), 13b(3), 13d(2) 2c — 8a(3), 12a(8), 12b(1), 12b(2), 12b(4), 12c(1), 12c(2), 12d 2d — 4b, 5b, 5c, 8a(3), 12a(1), 12a(2), 12a(3) 12a(4), 12a(9), 12b(4), 12c(4), 12e(1), 12e(2), 12e(3), 12e(4), 12e(5), 12e(6), 12e(7)(a), 12e(7)(b), 12e(7)(c)1, 12e(7)(c)2, 12e(7)(c)3, 12e(7)(c)4, 13e 2e — 12a(9), 12c(3), 13c(1), 13d(1), 13d(4) 2f — 12a(9), 8a(3), 12b(1), 12b(2)
PLAN OF INSTRUCTION NO 3ABR91431-2	DATE 25 JUL 1975	BLOCK NO III — PAGE NO. 21

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
b. Based on the observable problems and needs of an assigned patient, formulate a nursing care plan which will meet the patient's needs and provide a possible solution to his/her problems. Accuracy of 80 percent of checklist 3ABR91431-2-III-2b items is required.	(8)	**Instructional Materials** SW 3ABR91431-2-III-2, Planning and Giving Care to Mental Health Patients McClelland, Textbook for Psychiatric Technicians APA, Psychiatric Glossary **Training Equipment** Drug Display
c. Under supervised clinical conditions, observe, report, and record the behaviors of the assigned patient in accordance with the guidelines provided in SW 3ABR91431-2-III-2. Accuracy of 80 percent of checklist 3ABR91431-2-III-2c items is required.	(30)	**Training Methods** Discussion (5 hrs) Demonstration (12 hrs) Performance (84 hrs) Outside Assignments (32 hrs)
d. Under the supervision of an instructor provide care to the patient in the specific therapies of: (1) Occupational therapy, (2) Recreational therapy, (3) Group therapy, (4) Electro-convulsive therapy, and (5) Administration of drugs following guidelines provided in SW 3ABR91431-2-III-2. Accuracy of 80 percent of checklist 3ABR91431-2-III-2d items is required.	(30)	**Instructional Environment/Design** Classroom (5 hrs) Laboratory (Hospital) (96 hrs) Home Study (32 hrs) Group/Lock Step **Instructional Guidance** The instructor will select the student experiences, assist the student in planning care and approaches, supervise the care, and evaluate their performance. Students will tour the State Hospital to compare acute and chronic stages of mental illness and to correlate classroom material with clinical experience. Assigned a patient, the student will write daily interaction notes and submit them to the instructor each Monday for approval. Students will also visit available community resources such as the Community Counseling Center, Sheppard AFB, Texas. Students will prepare patient reports and present them to the class. The final report is a nursing care study based upon all the information and experience compiled during the period of hospital observation. A weighted system of measurement is used in evaluating the study. The study will then be presented orally in class.
e. Under supervised clinical conditions, admit a mental health patient to the unit according to the procedures outlined in SW 3ABR 91431-2-III-2. Accuracy of 80 percent of checklist 3ABR91431-2-III-2e items is required.	(2)	
f. Using the data previously collected on the assigned patient, write a comprehensive nursing case study as outlined in SW 3ABR91431-2-III-2. Accuracy of 60 percent of the checklist 3ABR91431-2-III-2f items is required.	(20)	

PLAN OF INSTRUCTION (Continued)

UNITS OF INSTRUCTION AND CRITERION OBJECTIVES 1	DURATION (HOURS) 2	SUPPORT MATERIALS AND GUIDANCE 3
3. Related Training (Identified in course chart)	4	
4. Course Critique and Graduation	1	

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PREPARE THE MAN

STUDY GUIDE AND WORKBOOK 3ALR91431-I-2a

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

LEGAL AND MORAL ASPECTS

August 1974

10-12

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

60

PURPOSE OF STUDY GUIDES, WORKBOOKS, PROGRAMMED TEXTS AND HANDOUTS

Study Guides, Workbooks, Programmed Texts and Handouts are training publications authorized by Air Training Command (ATC) for student use in ATC courses.

The STUDY GUIDE (SG) presents the information you need to complete the unit of instruction, or makes assignments for you to read in other publications which contain the required information.

The WORKBOOK (WB) contains work procedures designed to help you achieve the learning objectives of the unit of instruction. Knowledge acquired from using the study guide will help you perform the missions or exercises, solve the problems, or answer questions presented in the workbook.

The STUDY GUIDE AND WORKBOOK (SW) contains both SG and WB material under one cover. The two training publications are combined when the WB is not designed for you to write in, or when both SG and WB are issued for you to keep.

The PROGRAMMED TEXT (PT) presents information in planned steps with provisions for you to actively respond to each step. You are given immediate knowledge of the correctness of each response. PTs may either replace or augment SGs and WBs.

The HANDOUT (HO) contains supplementary training materials in the form of flow charts, block diagrams, printouts, case problems, tables, forms, charts, and similar materials.

Training publications are designed for ATC course use only. They are updated as necessary for training purposes, but are NOT to be used on the job as authoritative references in preference to Technical Orders or other official publications.

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Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

SW 3ALR91431-I-2a
August 1974

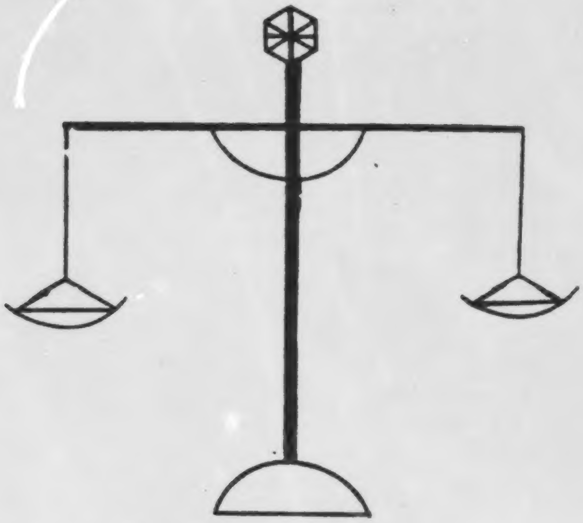
LEGAL AND MORAL ASPECTS OF MENTAL HEALTH NURSING

OBJECTIVE

State the basic concepts of Legal and Moral Aspects of Mental Health Nursing.

INTRODUCTION

As a basis for understanding the legal aspects of psychiatric nursing, it is important to know how a patient is admitted to a mental hospital, what rights he has and how he can be discharged. While you work with patients in the hospitals you must know your responsibilities and what will happen if you are negligent. If a patient with a security clearance is admitted to the ward, what steps must you take if he starts to talk about his job? We will try to answer these questions in this Study Guide/Workbook.



This supersedes SW 3ALR91431-I-2a, dated July 1973

DEFINITIONS

Voluntary - The patient willingly submits himself for hospitalization.

Involuntary - The patient is hospitalized against his will because he does not or cannot recognize a need for hospitalization.

Psychotic - Medical term used to indicate a severe mental illness where the patient has a break with reality.

Insanity - A rather vague legal term for psychotic or psychosis.

Commitment - Is a process whereby at the request of a relative, one or two doctors explain to a court why it is necessary to deprive the patient of his freedom.

Liable - Legally bound, as to make good any loss or damage that occurs in a transaction answerable; responsible.

Negligence - Failure to use a reasonable amount of care when failure results in injury to another.

A.M.A. - Against medical advice.

Incompetent - Is a legal status given to a person who has suffered a loss to his mental or physical capacities to the extent that he is incapable of handling his own affairs.

Appellate Court - This court handles appeals and reviews of cases.

Writ of Habeus Corpus - This represents a valuable human right provided by the Constitution of the United States. It provides for any person deprived of his liberty to be brought before a court of law where those individuals who would restrain him must defend their action. Any patient may force court action when illegal detention is alleged. The objective of the Writ of Habeus Corpus is to effect the release of the person from the institution.

DEVELOPMENT

TYPES OF ADMISSION

The two types of admission to the mental health wards are voluntary and involuntary.

The voluntary admission is the most desired method of getting treatment in a mental hospital. Anyone who is a resident citizen may apply in writing for admission at any private or state hospital. These laws vary in each state and a parent or legal guardian may request a person to be admitted voluntarily if he is too ill to carry out the details of the admission, but is willing to have the application made. The patient, however, must understand and is willing to agree to the hospital rules for hospitalization and eventual discharge. The number of patients that apply for admission to a hospital is not large. Most patients that would apply for admission suffer from milder forms of mental illness and usually find treatment from either private psychiatrists or mental health clinics. A person who recognizes that he is mentally ill and voluntarily admits himself for hospitalization will usually participate more actively in the treatment program. In the military, a patient would seek admission at the mental health outpatient clinic or the emergency room at the hospital.

The mentally ill military member is subject to military control and his hospitalization can be ordered by the doctor without going through any special judicial procedure. The patient is given an admission authorization form to sign; as minor as this may seem, he is voluntarily admitting himself to hospitalization. Every effort is made to encourage the person to voluntarily admit himself to the hospital, even though he is admitted regardless of whether or not he signs the form.

REQUEST FOR EVALUATION

In addition to a request for self-evaluation or admission to the mental healthunit, a patient may eventually be hospitalized through other channels. A legal officer may request his client be evaluated because of legal action pending. The commander may request an individual be evaluated because of inappropriate behavior or disciplinary problems. Medical doctors from other departments of the hospital may request a patient have a mental evaluation.

Prior to separation from the service, the Physical Evaluation Board may request a patient be evaluated because of a past history of mental illness. When a patient is seen in the emergency room, after a suicide attempt, he is in essence, asking to be evaluated. All of these are requests for evaluation, but only the doctor can order hospitalization.

Now that we have talked about voluntary admissions and requests for evaluation, let's look at the more complicated involuntary admission.

INVOLUNTARY

The involuntary admission is the patient that is hospitalized against his will and cannot or will not recognize a need for hospitalization. The patients that are usually involuntarily admitted to a mental hospital are those patients that are uncontrollably acting out, psychotic, or have misconceptions about mental hospitals. Since the military mentally ill patient can be hospitalized without court procedures, there is relatively little or no legal problems concerning the admission procedure. However, our civilian counterpart mental hospitals have many varied laws on involuntary admissions. We will cover these basic laws and terms that apply to most states.

Although you may not be working with patients that are directly affected by these laws, you will be coming in contact with patients who have either been in a state hospital or who will go to one when they leave the Air Force hospital. Retired Air Force personnel and dependents of active duty personnel may be limited on the time they are allowed to have treatment in military hospitals and must seek subsequent treatment at state and private hospitals. You will be able to assist patients and alleviate their fears of state hospitals by informing them of procedures in admission and legal rights they have at the state hospitals.

States vary in determining who will be hospitalized through court proceedings. Some state standards say the person must be dangerous to himself and others or simply a person in need of care or treatment. This hospitalization can serve many purposes: to protect society, to rehabilitate the patient, or to relieve the patient's family of a heavy burden. The constitutionality of hospitalizing the mentally ill is supported as long as there is fairness in protecting the person's right to notice of the proceedings and to a fair hearing.

COMMITMENT

Each state has enacted elaborate legal safeguards to prevent members of one's family or other designing persons from confining an individual in a mental hospital for ulterior purposes. These are "commitment" laws which prescribe how a patient may be admitted and confinement continued as long as necessary. This procedure varies widely among the states. It is desired that these laws governing commitments be simple and not subject the patient to embarrassment or unpleasant publicity. The following is a commitment procedure that has worked satisfactorily in many states for several years.

The first step in a commitment procedure is a petition. The petitioner usually is a member of the family but can be any citizen, police officer, or executive of an institution. Next comes the examination by the physicians that sign the commitment papers. These physicians cannot be close relatives of the patient nor can they be on payroll of the receiving institution. The time between the examination and the judicial determination is short since the patient's mental condition may change. The next legal procedure is that the patient is required to be given notice that he will be committed. Psychiatrists frown upon this procedure as it affects some of the sicker patients more abruptly. A severely suspicious person given notice of commitment may try to flee or attempt violence. A depressed person may commit suicide upon receiving this notice. This procedure is defended by saying this is the only way to preserve the civil rights of the patient and to prevent him from being rushed into the mental hospital without due cause.

In accordance with a state law, a wife swore out a warrant, the sheriff arrested the patient and he was taken to jail to await a hearing. He hanged himself in the jail. Obviously, his legal rights were upheld, and he was not committed to a hospital without due process and a chance to appear before the judge. If he had been hospitalized, perhaps he would be alive today. At times the public is so intense with the alleged infallibility of legal procedure that they insist on protecting and fail to see the difference in medical rights and legal rights.

The point at which a patient is definitely declared committable to a mental hospital is at the hearing. In most states, after all the facts are presented, the judge makes the official decision that the patient is committed.

Although the patient is committed to the mental hospital, he has certain rights. Now, let's look at the natural and civil rights of every person compared with the legal rights of the committed patient.

LEGAL RIGHTS OF PATIENTS

NATURAL RIGHTS

A natural right pertains to every person as a human being; the right to be protected from assault, insult, and slander.

A mentally ill person never forfeits his natural right except when he is compelled to accept treatment that might be construed as an assault if performed on a mentally competent person without proper written consent. An example of this treatment would be Electro-Convulsive Therapy.

Electro-Convulsive Therapy is when the patient is given an electrical shock to create a controlled convulsion, while the patient is sedated. Written consent, or an authorization, has to be obtained from the patient which allows the physician to do this treatment. If the patient is not competent to make this decision, then the patient's close relative must be contacted to secure consent. However, the military member can be ordered by the physician to accept Electric Shock Treatment.

CIVIL RIGHTS

When we talk of civil rights, we are referring to the rights all of us have as a citizen. These civil rights designate such privileges as the right to buy, sell, and hold property, right to vote, hold office, practice a profession, right to marry, engage in a business, institute divorce proceedings, and sue for damages. The only time we have our civil rights taken away is when we are declared incompetent.

A point should be made here to distinguish between incompetent and commitment. When a patient is declared incompetent, he is not capable, either mentally or physically, of handling his own affairs. We are concerned more here about the patient's mental status. A competent person has the mental capacity to carry on everyday affairs. To be incompetent, one must show a disorder of thinking that leads to impairment in judgement such as a person dissipating his money until he is broke or a victim of designing persons that take funds from him. If the patient is incompetent to manage his affairs or transact business, a relative or close friend will file a petition with the appropriate court for the appointment of a guardian for his estate.

A committed patient is deprived of his freedom by being placed in a hospital via a court order. See the definition of commitment. However, a committed patient has certain rights which allow him to do things the incompetent patient cannot do.

RIGHTS OF THE COMMITTED PATIENTS

Commitment by itself does not, in all states, suspend a person's civil rights. There are six states where patients are declared incompetent when committed to the mental hospital. These six states, where the civil rights of the patient is automatically relinquished are Arizona, Colorado, Indiana, Tennessee, Virginia, and Washington.

-The rights of a committed patient vary from state to state. Some of the standard rights that apply to most states include:

- Communication with legal counsel and the court that committed him.
- Communication with the superintendent of the hospital, the Department of Mental Health and the governor.
- Visits from the clergy.
- Writ of Habeus Corpus - A Writ of Habeus Corpus may be issued on behalf of any patient committed as insane, who later alleges that he has regained his sanity and is being illegally detained. A hearing is then arranged to determine his sanity and alleged unlawful restraint.
- Financial transactions.
- He can marry if he understands the marriage contract.
- Can make a will if he understands he is making one.
- He can communicate by letter with family without censorship. Some of the other mail may be censored on occasion to prevent embarrassment to the patient and family.
- Divorce - A mentally ill person cannot institute divorce proceedings nor can his spouse. Since psychosis is a disease, the spouse of the patient has no more basis for asking for a divorce than for pneumonia or a broken leg. Most states require that prior to a divorce being granted to the spouse of a patient, the patient must be declared "incurably insane" and be hospitalized over 5 years.
- The committed patient still has the right to vote.
- His records are shielded against publicity.

As you can see, the committed patient is limited, yet still has a considerable amount of "freedom." If a patient is committed and then declared incompetent, a guardian would be appointed by the court. This guardian may be a relative, but not absolutely; a bank could also be appointed to handle the patient's affairs.

The purpose for declaring a person incompetent is primarily to protect his property and to protect his person.

Mr. Grey, a sixty-three year old widower, was involved in incompency proceedings brought on by his son, who wanted control of his affairs, including twenty thousand dollars left to Mr. Grey by his late wife's inheritance. It was brought before the hearing that Mr. Grey had remarried again at the age of sixty-two to a girl thirty years his junior, and that he had divorced her two months later. It was also disclosed that he had recently bought a country cottage and some land, apparently on impulse, and that he was now trying to sell it. These facts and testimony by two doctors allegedly showed a serious defect of judgement and a weakening of his mental faculties.

The court in this case declared Mr Grey incompetent, but was overruled by the appellate court. This shows some of the problems that incompetency raises. Here there is no evidence that the individual is insane or in need of treatment. The question is whether Mr Grey should have his property taken from his control to better conserve and protect it. In this case, the court has to decide whether recklessness or eccentricity is the same as incompetence. Not in all cases can the law step in when a person mismanages his affairs unwisely.

Perhaps now you can see that when a patient is sent to a mental hospital, he has certain legal rights that protect him. These laws are not the same in all states and some laws need to be improved. Now let's turn to the type of responsibilities you will be concerned with as a Psychiatric Ward Specialist.

RESPONSIBILITIES OF THE PSYCHIATRIC WARD SPECIALIST IN PROVIDING CARE TO PATIENTS

DUTY IN THE LAW OR NEGLIGENCE

One must conduct himself in a reasonable and prudent manner for the avoidance of injury to other people and other property. If a person has had special training and experience in a profession, additional duties, and legal responsibilities are thus acquired. This inheritance of duty does not require an enactment of law. Since all of you have been awarded a (90230) title of Medical Service Specialist, you have acquired the duties and responsibilities inherent in that job.

ADMINISTRATION OF DRUGS

Some precautions to remember when administering drugs to patients are:

Know the right patient, time, drug, dosage and route. You should also be familiar with the therapeutic effects and side reactions of tranquilizers and anti-depressant drugs. Psychiatric patients might be observed to make sure they swallow medications. Some patients are very depressed and suicidal and may save medications for a suicidal attempt when he has accumulated several pills. The suspicious patient may feign taking medications for fear it is poison. The specialist should confront the patient if it appears he has not swallowed the medication and then ask him why and inform the nurse of your observation.

APPLICATION OF RESTRAINTS

Restraints should be applied correctly to prevent impairment of circulation and nerve damage. If the patient is placed in restraints over a long period of time periodic removal of each restraint may be necessary. In the class you will have on restraints; we will show you how to put a patient in restraints without injury to yourself or the patient.

CONTROL OF HAZARDOUS EQUIPMENT

On the psychiatric ward patients will be doing most of the ward cleanup. Your job involves joint supervision with the patient foreman. The idea is to get all pateints to share in cleaning the ward which is their home while they are hospitalized. When psychotic, suicidal, or confused patients are involved in cleaning keep poisonous cleaning agents locked up or supervise the activity closely so these patients will not be tempted to ingest the poison. When patients are admitted to the ward inspect their belongings for medications, knives, razors, or sharp instruments and lock up when appropriate. If a patient insists on keeping medications, report it to the nurse.

LACK OF SUPERVISION

Suicide - When a patient is placed on suicide precautions, usually a Psychiatric Ward Specialist may be assigned to this patient on a one-to-one basis. It is your responsibility in this specialist-patient relationship to prevent this patient from harming himself. In this relationship, the most effective preventive measure is to establish a relationship which causes the patient to feel that someone is interested, cares about him, and wants to help him. It is felt by most nursing staff that over-protective approaches communicate to the patient how the staff expects him to behave. Any statement the patient may make concerning suicide must be reported immediately, recorded, and the other members of the psychiatric team should be informed. It is not easy to decide how rigorous suicidal precautions should be; it is important that the therapeutic atmosphere of the ward not be affected because of rules applied to the suicidal patient, such as locking the main door to the ward.

Elopement - Some patients feel they are not mentally ill and see no reason for staying in the hospital. Other patients believe they are victims of an injustice and try to escape from the hospital. The confused or disoriented patient may wander away from group activities off the ward. It is important to count patients when leaving the ward and arriving at the activity and to insure all pateints are accounted for when returned to the ward. If you are familiar with the patients, you will be able to inconspicuously count them and, thus, can avoid pointing to them like a flock of sheep as they leave and return to the ward. On occasion, patients may have appointments at various clinics in the hospital and join the group late.

APPLICATION OF TREATMENTS

Although treatments are minimal on the psychiatric ward, patients do have physical ailments that need treatment. Review procedures if in doubt about giving treatments to patients. Most patients are capable of administering their own treatments provided they are given explicit instructions by you. Some treatments the coherent patients may administer are enemas, cleansing wounds, soaking their feet, and applying heat or ice pads.

If error, trauma, or death result from negligence in any of the above mentioned areas, the following may occur:

- An Article 15 for the specialist.
- Law suit or imprisonment for the nurse.
- Law suit or imprisonment for the doctor.

Now that you know what your responsibilities are in providing care to patients, let's turn to what you do when security violations occur.

STEPS TO BE TAKEN WHEN SECURITY VIOLATIONS OCCUR

Patients with security clearances of a very secret nature may frequently be admitted to the mental health ward. The patient's case should not be discussed with anyone off duty who does not have a need to know. The patient's chart is not to be removed from the unit. The charts are not to be read by any unauthorized persons. Doctors may occasionally remove the chart from the ward for review and may have to be reminded to return it. If you see any visitor on the ward that you do not know, ask his reason for being there. Report to the nurse or doctor anyone that attempts to read patient's chart. All legal officers, security policemen and OSI agents must clear through the patient's doctor prior to visiting the patient. Occasionally, the patient's contacts will have to be controlled or the patient isolated until he is debriefed by a security police officer or NCO with an equivalent or higher security clearance.

DESCRIBE PROVISIONS FOR DISCHARGE

A patient in the military may only be discharged after the doctor has written a discharge order. The written order by the doctor may return the patient to duty; to civilian life by use of a medical discharge or recommend administrative action to the patient's squadron commander. As a result of medical discharge the doctor may send the patient to a (V.A) Veterans Administration Hospital or a state hospital near the patient's home.

Military dependents are not controlled by the military. They may sign out against medical advice, (AMA). However, the right to sign out against medical advice stipulated that they may forfeit their right for future treatment. If the dependent patient is a threat to other people or self, the psychiatrist may call the parents, spouse, or civil authorities and recommend the dependent patient be committed to a state or private mental hospital.

This basic knowledge is to help you prevent legal difficulties. Your responsibility in caring for psychiatric patients in essence insure the life of the patient.

QUESTIONS

LEGAL AND MORAL ASPECTS OF MENTAL HEALTH NURSING

1. A process of depriving a patient of his freedom by hospitalization is best called ________________________________.

2. A military member is subject to military control and his hospitalization can be ______________________ by the ________________________.

3. Under the listed rights of committed patients most states require that prior to a divorce being granted to the spouse of a committed patient the patient must be declared ____________________________ ________________ and hospitalized ________________ years.

4. The legal responsibilities of a Psychiatric Ward Specialist are ______________ because of special training and experience in this profession.

5. In the administration of drugs to mental patients you should be familiar with ______________________ and ____________________ of tranquilizers and antidepressant drugs.

6. Why should you make sure the patient swallows medication?

7. How can you prevent a suicidal patient from harming himself? (Describe your relationship).

8. If a Psychiatric Ward Specialist is found to be negligent in his duties he may get an ________________________________.

9. The mental patient may be discharged from the hospital only after a doctor's order has been written. Circle one.

TRUE or FALSE

10. Dependents on the Mental Health Ward have the right to sign out of the hospital against medical advice, AMS. Circle one.

TRUE or FALSE

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

INTRODUCTION TO MENTAL HEALTH NURSING

July 1975

10-12

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, 76311

SW 3ABR91431-2-1-3
July 1975

INTRODUCTION TO MENTAL HEALTH NURSING

OBJECTIVES

When you have completed this lesson, "Introduction to Mental Health Nursing," you should be able to describe the characteristics and aims of the United States Air Force Mental Health Nursing.

INTRODUCTION

The application of the principles of mental health nursing is a skill which you will find valuable in the care of patients regardless of where you are. There have been, unfortunately, misconceptions about mental illness and the mentally ill. Only in recent years has there been strengthened communication between psychiatric hospitals and the community. It is not unusual, therefore, that some of you may enter your first experiences in psychiatry with feelings of apprehension. An opportunity to observe directly a psychiatric ward environment as it exists often causes you to alter your present misconceptions and feelings. After becoming acquainted with the patients you will usually begin to feel much more comfortable in the new setting.

INSTRUCTIONS

This instructional program is a combination audiovisual presentation and workbook. You will accomplish this instructional package in Room 1026 of the Learning Resources Center. You will complete the audiovisual presentation and then complete Exercise "A."

The audiovisual technician will direct you to a student carrel that has been prepared for this lesson. He will show you how to operate the audiovisual equipment. Once you start the program, follow the step-by-step directions. If you have trouble, push the stop button on the cassette unit, and get help from the AV technician. DO NOT TURN OFF THE SLIDE PROJECTOR.

This supersedes SW 3ALR91431-I-2b, January 1975

EXERCISE A

1. Define Mental Health:

2. List characteristics of good mental health:

3. What are some ways a person can stay mentally healthy:

4. What are the goals of mental health nursing?

ANSWERS TO EXERCISE "A"

1. Mental Health implies a feeling of well-being and an ability to function at a full capacity physically, intellectually, and emotionally.

2. Freedom from excess anxiety, guilt and depression, a general contentment of happiness in interpersonal relationship, recognizing and handling one aggression without damaging others, an objective view of oneself, sexual identity.

3. Maintenance of physical health, socialization, opportunity to react, to ventilate, and receive support and guidance, useful to others, some routine for living, prevention of abuse of alcohol or drugs.

4. To provide optimum care, to provide therapeutic environment, to provide a constructive experience for patients, to provide improvement in care, treatment and rehabilitation for the mental ill.

INTRODUCTION

Because each of you will be associated with military psychiatry, each of you will need to know why military psychiatry was established and for what purposes it was established.

Some statistics of mental illness will show us how deeply important it is for each of us to be aware of what mental illness is and how it can affect us.

The last part of this workbook will be devoted to the history of psychiatry and to historical facts related to mental illness. There is a history to mental illness just as there is a history to anything. A history of mental illness, though it is not merely a history of facts, is a history of man's eternal fears, his perennial hopes, and the physical, social, and philosophic devices which are so characteristic of man.

INSTRUCTIONS

Read this workbook and answer the questions on page 13.

INFORMATION

Four Main Purposes of Military Psychiatry

In World War I (1917), psychiatrists were assigned to combat divisions. Mental illness dropped to one-half the amount who were mentally ill in the Mexican Border Campaign of 1916.

In 1941, during an economy move, psychiatrists were dropped from the manning documents and instead, the services relied on tight screening processes at induction centers.

In 1943 the US Army was losing as many men each month by rejections and discharges as were being inducted. The psychiatrists were added to each combat division again, and the rate of mental illness was reduced by thousands.

In Korea, the rate of mental illness was two-thirds lower than in World War II. So by trial and error, an expensive trial and error resulting in many thousands of possibly prevented mental cases, the military discovered that psychiatrists were needed in the military.

With this background information we can examine the first important purpose of the military psychiatrist service--prevention.

PREVENTION. The psychiatric service in the military has the job of trying to prevent mental illness among the members of the military service and also among dependents of the military. In order to prevent mental illness, early detection is needed. The psychiatric service can prevent mental illness by detecting a possible future mental problem and then correcting the problem. Supportive treatment is used to prevent the problem from becoming too big for the person to handle. Counseling in the outpatient department is used, also child guidance and group therapy by the outpatient department can be used to prevent mental illness. Community mental health centers on most bases are excellent in their approach to preventing mental illness.

EVALUATION. The second purpose of the psychiatric service is the evaluation of the patient. Whether the patient is an outpatient or an inpatient, he is evaluated. The outpatient is evaluated in the clinic or by the community mental health center. This evaluation will sometimes recommend that the patient should be hospitalized. The patient who is hospitalized is evaluated first by the psychiatrist. He will make recommendations as to discharge from the Air Force, crosstrain into another field, return to duty, or treated for the illness immediately. The psychologist will also evaluate the patient by using tests such as the MMPI, OTIS, sentence completion, and House-Tree-Person Test. The patient is also evaluated by the nurse, specialist, and by other doctors and staff such as occupational therapy and the recreational therapist.

REHABILITATION. The third purpose is to help the patient back on the road to recovery. After the patient is evaluated and diagnosed, treatment is provided to help the patient to hopefully return to duty. The hospital is interested in the recovery of the total person emotionally, mentally, socially, physically, and spiritually. The rehabilitation consists of different therapies such as OT (Occupational Therapy), RT (Recreational Therapy), and IT (Industrial Therapy). In the hospital it is the responsibility of every staff member to help provide the proper treatment which will help the patient recover.

DISPOSITION. The last purpose of the military psychiatric service is the placement of the patient according to his mental status. The patient could return to duty with no follow-up treatment required. The patient could be returned to duty and referred to the outpatient clinic. The patient might be sent to the VA hospital for further treatment. Dependents are sent to a state hospital or can be referred to community mental health agency.

Statistics of Mental Illness

Conservative estimates indicate that at least one in every ten persons (a total of 20,000,000 in the US) will at sometime in his life have some form of mental or emotional illness (from mild to severe) that could benefit from professional help. One-half of all the hospital beds in the US are filled with mentally ill patients. The military has its own set of statistics concerning mental illness. 20% of all military medical discharges are for psychiatric reasons. Psychiatric problems rank third in loss of duty hours. The psychiatric service in the Air Force has its largest facility at Sheppard AFB, Texas. The outpatient clinic at Sheppard sees over 1800 patients per month. The average daily load of inpatients on psychiatric wards at Sheppard is 112 including men and women.

Historical Facts Related to Mental Illness

To begin to study the history of mental illness we must begin with studying the history of man himself. When, indeed, did man's "history" begin? Should man's history be dated from the two-million-year old crude artifacts discovered by J.B. Leakey in the Olduvai George, Africa, or from man's primeval but already artistic paintings as recorded a mere fifteen thousand years ago in caves? Whenever we date man's beginning we must realize that since his beginnings he has been involved in mental processes. Man, during his earliest development, experienced what is often thought of as man's three principle sources of anxiety; his physical well-being, his social security, and his immortal place in the universe. Our history will be a history of man's feelings toward mental illness, a disease which has been with man since his conception.

ANCIENTS (Prehistoric - 1000 BC)

As we have stated previously, the mentally ill have always been with us to be feared, marveled at, laughed at, pitied, or tortured, but all too seldom cured. Their existence shakes us to the core of our being, for they make us painfully aware that sanity is fragile. To cope with their ills, man has always needed a science that could penetrate to where the natural sciences can not probe into the universe of man's mind.

Prehistoric man used witch doctors and a strong belief that man could control the world around him. Our earliest evidence that man has tried to treat the mentally ill comes from ancient skull found by antropologists. These skulls had small holes chipped into the side of them. We call these skulls trephined skulls. These prehistoric people must have felt that headaches, convulsions, and mental illness was caused by evil spirits found in the head, and the way to cure the person was to release the evil spirits by chipping holes in the head. Remains of skulls that have been found show that some of the patients did not die from the hole in the head because the skulls were healed, but the healing showed that their skulls had been chipped at some time.

Early Egyptians used different types of therapies to cure the mentally ill. They encouraged the patients to occupy their time with recreation, work, or cruises on the Nile. The early Egyptians were the first to recognize emotional disorders. They described hysteria in women. Hysteria (histeron-uterus) they believed was caused by the malposition of the uterus and therefore they fumigated the vagina, hoping to lure the uterus back into natural position. This treatment was used even by Plato and Hippocrates, the Father of Medicine.

CLASSICAL ERA (1000 BC-400 AD)

This era is often called the "golden age of Greece." This age marked the beginning of medicine with the writings of Hippocrates. The major type of therapy used during this era was sleep therapy. The patients would, under the direction of a priest, sleep and the dreams would tell them what needed to be done in order to be cured.

The following is an example of this therapy being used. Strepsiades has come to Socrates to obtain counsel about his debts:

Soc: Come, lie down here.
Strep: What for?
Soc: Ponder awhile over matters that interest you.
Strep: Oh, I pray not there.
Soc: Come, on the couch!
Strep: What a cruel fate.
Soc: Ponder and examine closely, gather your thoughts together, let your mind turn to every side of things. If you meet with difficulty, spring quickly to some other idea; keep away from sleep.

Hippocrates described melancholia and epilepsy. Blood letting and purgatives were used in an effort to treat the mentally ill. When a patient did not eat they placed him between two patients who would eat. Rooms for excitable patients were quiet, cool in the summer and warm in the winter, and dull in color. These practices are still being used today in most hospitals for the mentally ill. During this era Aristotle made observations which influenced human psychology. He described the five senses. Touch, he said, is the most important and basic sense; taste is similar, but restricted to touch with the tongue. Smell, sight, and hearing function through distance. Imagination he described as a faculty of awakening a mental image in the absence of the original object. Memory is, for Aristotle, not merely a passive phenomenon, but an activity. He described all sensations as being either painful or pleasurable and reguarded thinking as directing strivings toward the reduction of pain. Plato believed that the mentally ill who committed crimes were not responsible for these acts and should not be punished the same as normal persons. This era made possible the further development of all natural sciences and replaced the magic-mystical religious explanations with a rational orientation toward the world and were therefore the true originators of our present era.

MEDIEVAL ERA (400 AD-1200 AD)

The citizens of ancient Greece at the height of their civilization found their inner security in knowledge and reason. The Romans adopted some of the heritage of Greece concerning their views toward man and mental illness. As these empires began to decline fear, unadulterated and naked, felt by rich and poor alike, became the central dynamic social issue. The first 500 years of this era were chaotic, confused and fearful, made so by wars, famines and plagues. Christianity satisfied many of the emotional needs of the demoralized masses. The church became a refuge and the monks treated the ill. Humane hospitals were established to care for the mentally ill. One such hospital is located at Gheel, Belgium. This is a colony run by the mentally ill to care for the mentally ill and has become a shrine to the mentally ill. It is still in existence today. Through most of this era the church was the central figure in society; it was not until close to the end of this era that a belief in the supernatural began to influence the treatment of the mentally ill. The monks began to think that the supernatural influenced illness. They began to think the mentally ill were evil. Witch hunts began to spring up throughout Europe.

RENAISSANCE (1200-1500 AD)

The Renaissance marked Western man's reorientation toward reality. Although the battle against superstition was not won during this era, the turning point was reached. Western man was committed to seeking the truth about himself. Man's body, with all of its complexities, was rediscovered.

Man's mind and spirit were re-illuminated. Some doctors believed the mentally ill could be cured, but most thought they were incurable. Most important, the vital principle of objective observation was re-established and has proven the most valuable and enduring part of the legacy of the Renaissance.

ERA OF REASON AND OBSERVATION (1500-1600 AD)

This is the age of natural science. Galileo invented the telescope, Newton worked with physics, and Robert Hooke was working in medicine. The writings of Shakespeare, Cervantes, and Lock influenced man's feelings about himself and mental illness. William Harvey professed that everyone should "learn and teach from the fabric of nature." There was a general tendency to believe that mental disturbances arise from purely psychological reasons. Asylums were built to house the mentally ill, but their care was notoriously bad. In 1547 the Monestary of St. Mary of Bethlehem at London was built. The name was later shortened to "Bedlam." In this monestary the violent patients were exhibited to the public while the less violent were forced to beg in the streets.

ENLIGHTMENT ERA (1600-1790)

The conditions at the beginning of this era were very bad. The reasons for this was an ignorance of the nature of mental illness, a deeply felt dread of the insane, and a belief that the mentally ill were incurable. For these reasons,the mentally ill were still kept in chains the majority of the time. The code of the day was "if a dangerous madman has no relatives he shall be placed in prison." Johann Reil, one of the most advanced psychiatrists of the era wrote:

> "We incarcerate these miserable creatures as if they were criminals in abandoned jails, near to the lairs of owls in barren canyons beyond the city gates, or in damp dungeons of prisons, where never a pitying look of humanitarianism penetrates; and we let them in chains, rot in their own excrement. Their fetters have eaten off the flesh of their bones, and their emaciated pale faces look expectantly toward the graves which will end their misery and cover out shamefullness."

It was during this age that Philippe Pinel began to use a humane approach to the care of the mentally ill. Pinel considered that mental illness could be a result of environment and not just heredity as had been the belief for most of the past. Pinel asserted that it was impossible to determine whether mental illness symptoms resulted from mental disease or from the effect of the chains. He also insisted that doctors must live with patients in order to understand them. Moral treatment began to be used for the care of the mentally ill. William Tuke, a Quaker tea merchant established the York Retreat for the mentally ill. Tuke admired

Pinel and provided an atmosphere of benevolence, comfort, and sympathy for the patients. In the US a hospital in Philadelphia in 1756 established cells for the mentally ill. The first hospital for the mentally ill in the US was established in 1773 in Williamsburgh, Virginia. Benjamine Rush, the first American psychiatrist, established the first course in psychiatry in 1783. Rush believed that mental illness was caused by clogged blood vessels in the head. He used a gyrating chair which spun the patient in an effort to dissolve the clots in the head. Empiricism and rationalism, along with more sophisticated methods of observation and classification, brought the problems of mental illness into sharper focus and enabled men to regard the mentally ill with more compassion.

ROMANTIC ERA (1790-1840)

The Romantic Era was marked by a reaction, but a reaction in the direction of progress. In their new and enthusiastic concern over the nature of the mind, the Romantics brought psychiatry to the threshold of modern concepts and techniques. In their furthering of humane treatment of the mentally ill they saw each sick person as an individual demanding individually patterned treatment. In their origination of ideas about unconscious, the nature of dreams, and instincts and the complexity of the total personality, the Romantics enabled psychiatry to break away from classifications. The classifications were initially essential, but later became meaningless terms. This break through allowed psychiatry to return to a dynamic approach to mental illness and, with new discoveries in neuropsychiatry, made possible the birth of the modern age of psychiatry.

MODERN ERA (1840-Present)

During this age psychiatry became a separate and distinct form of medicine. In 1841 Dorthea Dix was teaching Sunday School in prison in the US. She was shocked at the conditions which the mentally ill and prisoners were subjected. She devoted the rest of her life to improving the conditions of the prisons and asylums. She was responsible for establishing 32 hospitals for the care of the mentally ill. The most well known is St. Elizabeth's in Washington, D.C.

Clifford Beers, an ex-mental patient, wrote a book "The Mind That Found Itself." This book brought to light the condition of the hospitals and led to improving of conditions.

The writings of Sigmund Freud influenced psychiatry. He concluded early in his career that in order to cure mental disease one must understand their nature and that in order to understand a phenomenon one must systematically observe it. This led to the vitally significant principle of psychoanalysis as a valid method of investigation. His principles were responsible for the emergence of the first comprehensive theory of personality based on observation and not merely on speculation. He made contributions to science in four areas; (1) research in anatomy of the nervous system and neurology, (2) studies in hypnotism and hysteria, (3) developed psychoanalytic method and, (4) made inquiries into structure of human personality and society.

Today researchers such as Harlow, Skinner, Adler, and Rank have opened the door to understanding the human mind. Mental hospitals have improved conditions and now there are many treatment facilities available for the treatment of the mentally ill.

There have been many advances in the field of psychiatry; however, much remains to be done in terms of educating the public to accept the mentally ill person and to help them get well. We should always remember that understanding removes fear of the unknown and without fear there is little room for superstition.

QUESTIONS

1. What are the four main purposes of military psychiatric?

2. Name one type of treatment used by the ancients to treat mental illness.

3. How did Plato feel about the mentally ill who committed crime?

4. Who was Benjamin Rush?

5. Who wrote "The Mind That Found Itself"?

PREPARE THE MAN

STUDY GUIDE AND WORKBOOK 3ALR91431-1-90

10-12

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

DUTIES OF THE PSYCHIATRIC WARD SPECIALIST

August 1974

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

PURPOSE OF STUDY GUIDES, WORKBOOKS, PROGRAMMED TEXTS AND HANDOUTS

Study Guides, Workbooks, Programmed Texts and Handouts are training publications authorized by Air Training Command (ATC) for student use in ATC courses.

The STUDY GUIDE (SG) presents the information you need to complete the unit of instruction, or makes assignments for you to read in other publications which contain the required information.

The WORKBOOK (WB) contains work procedures designed to help you achieve the learning objectives of the unit of instruction. Knowledge acquired from using the study guide will help you perform the missions or exercises, solve the problems, or answer questions presented in the workbook.

The STUDY GUIDE AND WORKBOOK (SW) contains both SG and WB material under one cover. The two training publications are combined when the WB is not designed for you to write in, or when both SG and WB are issued for you to keep.

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Training publications are designed for ATC course use only. They are updated as necessary for training purposes, but are NOT to be used on the job as authoritative references in preference to Technical Orders or other official publications.

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

SW 3ALR91431-I-3a
August 1974

DUTIES OF THE PSYCHIATRIC WARD SPECIALIST

OBJECTIVE

Select the duties of the Psychiatric Ward Specialist in the career ladder progression.

INTRODUCTION

As a Psychiatric Ward Specialist you are an important member of the psychiatric team. You are with the patient more than any other team member. In this position you influence the patient's recovery as much as any other form of treatment.

You are the most constant factor in the patient's environment. You will represent what is normal and those with whom the patient can identify. Your behavior serves as a guide for him to follow. You are the person with whom the patient can relate to regain his self-confidence, feelings of security, and social skills. The therapeutic and professional quality of this relationship is assured when you know what you are doing and why and how you are helping the patient.

Your duties in this career field will assist you to better understand people regardless of the profession you will pursue after your AF obligation. Your AF duties of working with the mentally ill can be challenging, rewarding, frustrating, disappointing, and at times, depressing. However, you will emerge from these experiences with a better understanding of yourself and your fellow man.

STUDENT ASSIGNMENT

1. Read Textbook for Psychiatric Technicians, Chapters 3 and 4, Pages 23-53.
2. Answer questions at the end of this Study Guide/Workbook.

This supersedes SW 3ALR91431-I-3a, dated July 1973

INFORMATION

DUTIES OF PSYCHIATRIC WARD PERSONNEL

Psychiatric Ward Specialist

Your job title is Psychiatric Ward Specialist and upon completion of this course you will be awarded the 3-level in your AFSC 91431. The title Psychiatric Ward Specialist also includes the AFSC 91451 and includes the rank of airman through staff sergeant. The 5-level is acquired after the completion of on-the-job training with which you will be involved at your permanent assignment.

Your duties are many and varied to include assisting with specialized treatments, performing general nursing services and ward duties and supervising other psychiatric ward personnel.

ASSIST PROFESSIONAL STAFF WITH TREATMENTS. The most constant and helpful type of treatment with which you will be involved is group therapy. Other types of therapies you will participate in are occupational therapy, recreational therapy and work therapy. Electroconvulsive therapy is another special treatment with which you may be required to assist, but you will have more information on these therapies in class.

OBSERVING AND REPORTING. Observing and reporting patient behavior to the nurse or doctor is important in assisting the doctor in planning treatment. Your reporting is also written to relay patient behavior to other shifts and team members.

THERAPEUTIC RELATIONSHIPS. You will maintain prescribed therapeutic relationships with patients. This is where you will act as a social therapist by using varied ways of interacting with patients. As an example: a prescribed treatment may be to talk about real things and only immediate environment or encourage the patient to ventilate feelings in group therapy. Sometimes, just sitting near a patient and showing interest is a prescribed treatment. This role of a social therapist with the patient is one of your most important duties.

PRECAUTIONARY MEASURES. There are times when patients may try to escape or try to injure themselves. These patients usually are confused or psychotic and it would be your job to be with them on a one-to-one basis or to observe closely to prevent injury and escape. There will be a class on protective measures and restraints to teach you how to do this safely.

PERFORMS GENERAL AND SPECIAL NURSING SERVICES. The treatments of medical diseases and surgical injuries on a psychiatric ward are considerably limited to what might be encountered on a medical or surgical ward. You may be asked by the nurse or doctor to treat minor ailments such as cuts and sprains suffered in recreational therapy. As in all hospital admissions, there are vital signs to take and record, along with specimens to collect and label. Patients, however, still have physical needs that need to be attended to such as: Feeding problems and assistance with personal hygiene activities.

AIR EVACUATION PREPARATION. Patients may have to travel to other hospitals for treatments. These may include local civilian hospitals for treatment and by airplane to a Veterans Administration Hospital or a larger military hospital for further treatment. If stationed overseas this will be done on a more frequent basis. You will become familiar with preparing patients both safely and comfortably for air evacuation in a class on Restraints.

PERFORM GENERAL WARD DUTIES. The first ward duty is also a treatment. This is the admission of the patient to the psychiatric ward. Along with gathering data such as measurement of vital signs and personal statistics, it involves a beginning therapeutic relationship between you and the patient. In your first meeting with the patient you should accept the patient as a person and show a true interest in him.

You may have to escort patients to various clinics, off ward activities and the dining hall, keeping in mind their safety as well as the safety of others.

Most patients are able to feed themselves; however, occasionally, you may have to feed a very regressed or confused patient.

HOUSEKEEPING OF THE WARD. On most modern psychiatric wards the patients will maintain the cleanliness of the ward. The reality is that they are capable of doing it and the ward is their "house" and they must keep it clean. Usually there is a patient who acts as the ward foreman and assigns patients to various cleaning details. You and the foreman can work closely to supervise the patients and insure the ward is clean.

MAINTAIN WARD SUPPLIES. It may be your responsibility to store, issue and requisition supplies for the upkeep of the ward. The items used most are linen such as pajamas, convalescents, sheets and towels. Emergency care trays from Central Supply must be renewed for sterility. Office and cleaning supplies are always in need of replenishment. Also, the Red Cross furnishes toilet articles, such as combs, toothbrushes, and toothpaste to those who do not have money.

MAINTAIN WARD RECORDS. This means filing reports in the patient's chart, recording vital signs and progress notes on the patients.

SUPERVISE PSYCHIATRIC WARD PERSONNEL. Training is continuous, as you become more experienced and proficient in your job you may be asked to conduct on-the-job training in psychiatric ward functions. There are new airmen assigned to the ward almost continuously.

If you gain the position of shift leader and are promoted you may be asked to write evaluations on the duty performances of your subordinates.

This briefly explains some of your duties and responsibilities as a psychiatric ward specialist. Now, let's look at the psychiatric ward technician and his duties.

Psychiatric Ward Technician

The psychiatric ward technician has a seven skill level (91471) and includes the rank of TSgt and MSgt. He usually is the ward NCOIC or is the NCOIC of inpatient services. This means he would be in charge of all the enlisted psychiatric ward personnel on the ward or in the hospital.

He assists in the care and treatment of psychiatric patients and supervises psychiatric ward activities. The psychiatric ward technician holds a supervisory position and assists subordinates in the nursing care of difficult psychiatric patients.

PERFORMS PSYCHIATRIC WARD ADMINISTRATIVE FUNCTIONS. He analyzes requirements for personnel, supplies and equipment and makes recommendations to superiors for these needs. He supervises the storage, issue and requisition of supplies and equipment on the wards. He is responsible for utilizing personnel to insure economy of operation and in accordance with directives and regulations.

SUPERVISES PSYCHIATRIC WARD PERSONNEL. As new personnel are assigned to the ward it is the job of the technician to orient them to his supervisor shift leader and other staff members and inform him of his responsibilities. He plans duty schedules and assigns work to subordinates. If you want a special day off or want to go on leave, you should see this sergeant. The psychiatric ward technician is responsible for training you in new methods of psychiatric treatment as these vary slightly in each hospital. Your job performance is evaluated by the technician and is called an Airman's Performance Report (APR). By using the APR he recommends promotion among the enlisted staff members.

Psychiatric Service Superintendent

The Psychiatric Service Superintendent usually holds a 9-level (91491) and is in the rank of Senior Master Sergeant or Chief Master Sergeant. He can be from either the 91471 AFSC or the Psychiatric Clinic Technician AFSC (91470). He supervises administrative and subprofessional psychiatric services activities. In this position he aids physicians with administrative actions such as Medical and Physical Evaluation Boards. He serves as manager in administration of the psychiatric service and can give assistance to both the NCOIC of outpatient services (Psychiatric Clinic Technician) and the NCOIC of inpatient services (Psychiatric Ward Technician).

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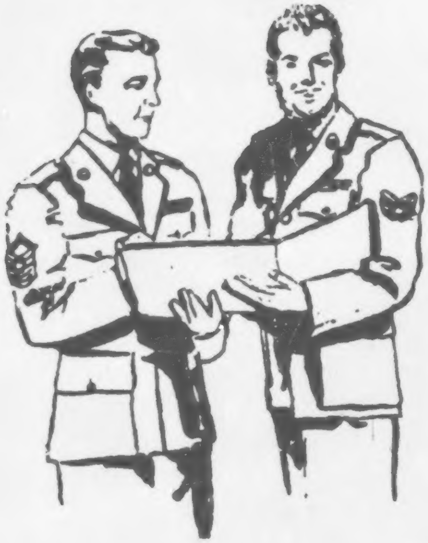

STEPS FOR ADVANCEMENT

On-the-Job Training (OJT)

After completing this course, AFSC 91431 is awarded to you. When you are assigned to a base and start to work as permanent party, your OJT from 3 to 5-level is started. Your ward supervisor and OJT trainer will assist you in obtaining your 5-level skill. This OJT training consists of studying material in this field according to the Job Proficiency Guide for a 5-level and then being given tests on this material by the OJT trainer.

The other aspect of training is the experience gained on the ward in the six month minimum period that you must be on OJT for your 5-level. At the end of six months you will be granted your 5-level if you have satisfactorily completed the study material and tests, become proficient in the Job Proficiency Guide, and been recommended by your supervisor for the 5-level award. If, after eight months you have not completed your OJT criteria, you would then be counseled and given assistance in problem areas. At the end of 15 months if a person has not completed OJT he is then sent before a board to determine if he can continue in the present AFSC.

After you have completed OJT for 5-level and been promoted to E-4 your steps for advancement come under the Weighted Airman Promotion System.

WEIGHTED AIRMAN PROMOTION SYSTEM (WAPS)

The WAPS System selects airmen from E-4 to E-7 for promotion using standard weighted criteria. Listed below are the criteria in the WAPS System that you can achieve.

Specialty Knowledge Test (SKT)

The Specialty Knowledge Test is concerned with job knowledge and it is possible to get a maximum of 95 points. However, in the 914X1 career field there is no SKT Test that 914X1s can take, therefore it balances out to zero points for all personnel in this field.

Physical Fitness Exam (PFE)

This is a big factor for points for all personnel in the 914X1 career field and it does not mean physical fitness in the sense that we keep our body in shape. The PFE measures your knowledge of military subjects and management practices at a specific grade level, and a maximum of 95 points can be attained. It will be administered every cycle to new eligibles normally at the same testing session as the SKT. Once taken, the test results are valid for two cycles and will be recorded in the subsequent cycle together with the results of the new eligibles. You should prepare yourself for this examination by reviewing references and material available through your unit. Both the PFE and SKT will be scored using the percentile scoring method. These test scores are compared with other person's scores competing for promotion during the same cycle and of the same AFSC and promotion level.

Time-in-Service

Time-in-Service is computed by multiplying your total years of active federal military service by two.

Less than six months will count as one point and six months or more two points. Maximum points that can be accumulated are 40.

Time-in-Grade

Time-in-Grade is computed at the rate of one-half point per full month in grade up to the maximum of 60 points for 120 months in grade.

Over 15 days of a month count as a whole month. Maximum points that can be achieved are 60.

Decorations

Decorations are assigned specific points according to their order of precedence. As an example: Bronze Star--5 points; Air Medal--3 points; Commendation Medal--3 points. The maximum amount of points allowed is 25.

Airman Performance Reports (APRs)

The Airman Performance Reports will be used to measure your past job performance. The reports have a scale of rating different areas of how well you did the job. This report is written by your immediate supervisor. For E-1 through E-5 under three years service, one report is written every six months. The points are taken from the five most recent written reports and a maximum total of 135 points can be accumulated.

Below are the factors and maximum scores you can achieve in WAPS.

Factors	Maximum Points
Specialty Knowledge Test (SKT) Score	95
Promotion Fitness Examination (PFE) Score	95
Time-in-Service	40
Time-in-Grade	60
Decorations	25
Performance (APRs) Reports, total of five	135
TOTAL:	450

After looking at your personal factors you may see you will not get 450 points unless you have been in 20 years, had perfect scores on tests, and been a hero with decorations. Remember you are being compared with others in your field going for the same promotion level and taking tests at the same time during the same cycle.

Report Card

If you are not promoted, a report card will all the tallied points in each area is returned to you. This is helpful to show in what areas you can possibly improve for the next promotion cycle.

It is possible to make Staff Sergeant in four years. This depends, however, on how well you apply yourself to your job and how well you prepare yourself for the WAPS Tests. GOOD LUCK!

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REFERENCES

1. AFM 39-1, Airman Classification Manual.
2. AFM 35-1, Military Personnel Classification Policy, Manual.

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QUESTIONS

Fill in the following blanks with 60% accuracy.

1. In a therapeutic relationship you will act as a ______________________.

2. You should accept the patient as a __________________________ in your ______________ ________________ with him.

3. Housekeeping on the psychiatric ward is one of the duties of ________________.

4. As a shift leader your responsibility may be to write __________________ _________________ on the ________________ of your subordinates.

5. The psychiatric ward technician holds a ____________________ skill level.

6. The _________________ _________________ _________________ usually holds a 9-level and serves as manager in administration of the psychiatric service.

7. The minimum length of time for OJT from 3 to 5-level is ____________________.

8. The ______________________ measures your knowledge of military subjects and management practices at a specific grade level and a maximum of 95 points can be attained.

9. If you have one year and seven months in-service you have accumulated __________ points for time-in-service under WAPS.

10. Time-in-Grade is computed at the rate of ___________________ per full month under WAPS.

10-12

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PROGRAMMED TEXT 3ABR91431-2-I-3b

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

TERMINOLOGY

June 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

PT 3ABR91431-2-I-3b
June 1975

TERMINOLOGY

OBJECTIVES

Define common terminology in current use in mental health nursing.

Diagnostic terms

Disorders of thought process

Disorders of affect

Disorders of motor behavior

Disorders of perception

General terms

INTRODUCTION

When a person becomes a part of any of the many working groups in the country, it means that he will have to learn how to communicate within the working group. If one does not understand the particular terms used to describe different aspects of his job, then his proficiency in his job will suffer.

Certainly the field of mental/health does not deviate from its other colleagues in medicine, in that it also contains many words to describe itself. As a layman in the field of mental health, it is next to impossible to comprehend the large range of words, terms and theories, but there is a definite need to start a foundation. It is important for you, as a forthcoming member of a Psychiatric Team, to begin laying your foundation by understanding the material presented in this publication. This will help you to communicate with your Psychiatric Team.

INSTRUCTIONS

1. Use as reference: A Psychiatric Glossary, American Psychiatric Association.

2. This is a programmed text. As you are completing this book, answer the questions. After each set of questions, check your answers and continue on. Complete comprehensive quiz when finished with all exercises.

This supersedes PT 3ALR91431-I-3b, August 1974.

INFORMATION

1. Diagnostic terms

A diagnostic term is a word that is used to determine the nature of an abnormality or disease. In psychology, it is a classification of a disease from a process of studying the symptoms, communicating with the patient and formulating the diagnosis.

Psychiatrists have a great number of diagnostic terms that vary from one school of thought to another. But most all of these terms used to describe functional mental problems are in one of the three following categories:

a. Psychosis - A break with reality. A marked deviation from normal thinking, feeling and acting. This is the most severe mental disorder.

b. Psychoneurosis - Most symptoms of this disorder are centered around anxiety. Anxiety is directly felt or unconsciously controlled by the use of defense mechanisms.

c. Character and behavior disorders - Behavior or actions that are socially unacceptable. This person feels little or no anxiety about his unacceptable actions. Examples are alcoholism, addiction and immature reactions.

2. Disorders of thought process

Often we represent various properties of a situation by symbols and then manipulate or organize those representations in ways which do not depend upon immediate perceptions or actual manipulations of objects. This process--using symbols to deal with relationships, objects or events not physically present to the senses--is called thinking.

A person suffering from a mental illness can still think, but because of the nature of his problems, his thought process has become abnormal.

a. Circumstantiality - Talking around the point for a long time before getting to the point--many tiresome digressions. Seen frequently in older senile patients.

b. Incoherence - Progression in a manner that cannot be understood. Confused, meaningless, disjointed sentences or phrases. Incoherence is used most often to describe speech.

c. Flight of ideas - Rapid digression from one idea to another; rapid progression with connection of ideas only by word sound or outside association. The goal never reached.

d. Blocking - Though obstruction; progression of thought suddenly ceases.

e. Delusion - A false belief without basis and in direct conflict with evidence.

f. Ideas of reference - Remarks by other persons are interpreted as accusations or depreciations. Patient has an impression that the conversation, smiling, or other actions of other persons have reference to him.

g. Loose Associations - One of the fundamental symptoms of schizophrenia. Thinking becomes haphazard, purposeless, illogical, confused, incorrect, abrupt, and bizarre.

h. Obsession - Illogical preoccupation with some object or idea; thoughts thrust themselves into consciousness against the conscious desire of the person.

i. Hypochrondria - Special obsession with one's health; exaggerated concern over physical health.

Before continuing complete exercise number 1 on page 7.

3. Disorders of affect

Affect is a word that is used to describe feeling, emotion, tone or mood. For instance, if you just found out that you were automatically being promoted to Major, your emotions, mood and feelings would be happy, and appropriately so.

With a mentally disturbed person, many times their affect is not normal. For instance, you tell a patient his mother has died and he starts laughing; his affect is inappropriate. Or, if you were talking with a patient about some very traumatic event in his life, and he sits there showing no feeling, no facial expression or mood; his affect is bland or emotionless.

The disorders of affect are:

a. Apathy - Absence of affect. Other terms for this would be a bland or flat affect. The person shows little or no feeling.

b. Euphoric - An exaggerated sense of well-being not warranted by the circumstances or conditions. Another term for this is indifferent elation.

c. Ambivalence - Positive and negative feelings occurring at the same time about a person, object, or situation. For example, loving and hating your last job responsibilities.

4. Disorders of motor behavior

Motor behavior is centered around the movements of muscles and organs. Two disorders of motor behavior are:

a. Compulsion - A repetitive, irresistible, unwanted urge to perform a certain act which is contrary to the person's conscious wishes or standards.

b. Waxy flexibility - Permitting the molding of the limbs into any position where they remain indefinitely.

5. Disorders of perception

Perception is a two-step process consisting of receiving and interpreting. Distortion may occur at either step. The normal mind may occasionally misinterpret what is perceived, but the error is soon recognized and does not persist or influence behavior. The opposite often occurs in the abnormal mind.

Two disorders of perception are:

a. Illusion - The misinterpretation of a real external sensory experience. Illusions always involve the distortion of a stimulus pattern.

Example: A line with >< at its ends (>———<) appears to us definitely longer than an equal segment with < > at its ends (<———>), but the ruler dispels this visual illusion.

b. Hallucination - A false sensory perception occurring without external stimulus. Hallucinations are generated from within the person and are generally considered evidence of abnormality. Hallucinations may occur in any of the 5 senses but auditory hallucinations are the most frequent followed by visual.

Before continuing, complete exercise number 2 on page 8.

6. General terms

As was stated in the introduction there are many words, terms and theories in the field of mental health. Here are a few general terms to add to your foundations in mental health that you, as a Psychiatric Ward Specialist, are building.

a. Functional illness - An illness of emotional origin in which organic or structural changes are either absent or develop secondarily to prolonged emotional stress.

b. Organic illness - Characterized by significant structural or biochemical abnormality in an organ or tissue.

c. Autism or Autistic thinking - A form of thinking which gratifies unfilled desires without regard for reality. Material thought about is derived from person himself in the form of daydreams, delusions, and hallucinations.

d. Preoccupied - Engrossed in one's own thoughts.

e. Acceptance - Accept without passing moral judgment. This is the first and foremost attitude for a Psychiatric Ward Specialist to develop.

f. Empathy - An objective and insightful awareness of the feelings, emotions, and behavior of another person.

g. Apprehension - Anticipation of evil or harm.

Before answering the comprehensive questions go to page 8 and do exercise 3.

EXERCISES

Exercise 1

Fill in the correct answer.

1. A type of mental disorder in which most of the symptoms are centered around anxiety is called ______________________________.

2. A thought obstruction where the progression of thought suddenly ceases is called ____________________________.

3. A false belief is a ____________________________.

4. The thought disorder of _________________________________ means the patient's thinking has become haphazard, purposeless, illogical, confused, incorrect, abrupt, and bizarre.

5. Most severe type of mental disorder is called ____________________.

6. Talking around a point for a long time before getting to the point is called ______________________________.

7. ______________________ ____________ ______________ means that remarks by other persons are interpreted as accusations or depreciations.

8. When a patient rapidly digresses from one idea to another and also progresses with ideas by connection of thoughts by word sound or outside association, it is called _______________________ _____________ ______________________.

9. Which type of mental disorders are characterized by a break with reality? ___________________________________

10. Illogical preoccupation with some object or idea is called an ______________________________.

11. The type of mental disorder characterized by the display of behavior and actions that are socially unacceptable is called a ____________ ______________________________.

12. If a patient's speech is very confused, meaningless and the progression cannot be understood, he would be displaying ________________.

13. A special obsession with one's health is called ________________.

Confirm your answers on page 13. Correct those answers missed and review again. Continue with the next module on page 4.

Exercise 2

Fill in the correct answers.

1. Seeing something that is not there is an example of a __________.

2. A word that is used to describe feeling, emotional tone or mood is called ______________________.

3. This patient does not want to wash his hands every half hour but he cannot resist the urge. This is an example of a _________________.

4. An absence of affect is called ______________________.

5. Having positive and negative feelings occurring about a subject at the same time is called ______________________________.

6. If you could lift this patient's arm above his head where it remained there indefinitely the patient would have ________________ ____________________.

7. An exaggerated sense of well-being not warranted by the circumstances or conditions is called ____________________________.

8. Misinterpretation of a real sensory experience is called an ________________________________.

Confirm your answers on page 13. Correct those answers missed, and review again. Continue with the next module on page 5.

Exercise 3

Answer the following questions.

1. Explain the difference between a functional illness and an organic illness.

2. If one is engrossed in his own thoughts, he is ____________________.

3. If you anticipate evil or harm you are ______________________.

4. A form of thinking which gratifies unfulfilled desires without regard for reality is called ______________________________.

5. What is the first and foremost attitude of the PWS? __________ ______________________.

6. To have an objective insightful awareness of another person's feelings and emotions is to be ____________________________.

Confirm your answers on page 14. Correct those answers missed, and review again.

ANSWERS TO EXERCISES

Exercise 1

1. Psychoneurosis
2. Blocking
3. Delusion
4. Loose associations
5. Psychosis
6. Circumstantiality
7. Ideas of reference
8. Flight of ideas
9. Psychosis
10. Obsession
11. Character and behavior disorder
12. Incoherent
13. Hypochrondria

Exercise 2

1. Hallucination
2. Affect
3. Compulsion
4. Apathy
5. Ambivalence
6. Waxy flexibility
7. Euphoria
8. Illusion

Exercise 3

1. A functional illness is of emotional origin and if there is any organ or structural abnormality it is developed secondary because of prolonged emotional stress. An organic illness means there is an abnormality or disease in an organ or tissue.

2. Preoccupied

3. Apprehensive

4. Austic thinking

5. Acceptance

6. Empathic

PROGRAMMED TEXT 3ABR91431-2-I-4

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

NORMAL NEEDS OF PATIENTS

July 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

PT 3ABR91431-2-I-4
July 1975

NORMAL NEEDS OF PATIENTS

OBJECTIVE

Describe the normal needs of psychiatric patients.

INTRODUCTION

The difference between mental health and mental illness is only a matter of degrees. In many situations the mentally healthy can become mentally ill very easily and quickly, and a person can be mentally healthy one day and mentally ill the next. Both of these individuals have things in common. They are all human beings with basic needs. These needs are divided into physical, emotional, social, and cultural needs.

INSTRUCTIONS

This text is designed so that you will go through it step-by-step. Each frame or step of instruction is designed to teach you a small bit of information. Confirmation of each step is given immediately below the slashes (/ / / /). You should slide a mark (piece of paper) down the page until the slashes are barely exposed. Read the information and respond as directed. Then, slide the mark downward and confirm your response. Do not proceed until you have responded correctly. If you require assistance, see your instructor.

INFORMATION

PHYSICAL NEEDS

The first section of this Programmed Text has to do with the Physical Needs that an individual has. The Physical Needs that all individuals have will be discussed first and then how these needs are modified by illness.

This supersedes PT 3ALR91431-I-4, January 1975

Food

The need for FOOD is a physical need which all organisms share. Without food no organism can survive, yet food also has many social associations that exercise considerable influence on the development of the personality. Hunger and food therefore are combinations of both physical and psychological factors. Some examples of the social influences of hunger and eating are:

1. Religion - some religions forbid their followers to eat certain foods.
2. Poor table manners can get a child into trouble. An example of this is a child who goes to the table to eat; thinking only of satisfying his hunger pangs. He eats too fast, puts his fingers in his food and spills his food. He is reprimanded by his father and becomes frustrated and irritated. Eventually he is told to leave the table. His hunger and poor table manners have gotten him into trouble.
3. Compulsive Eating - Sometimes an individual cannot achieve some goal in life, and the pleasure of eating is a substitute for other pleasures which are desired, but unavailable.

These are only a few of the social influences of eating, but one can easily see that our basic organic drive for food has been infiltrated with many social influences which change our belief and desire of eating.

Which of the following statements is NOT correct?

a. All organisms must have food to survive.

b. A person's religion can effect his eating habits.

c. Hunger is a combination of physical and psychological factors.

d. Compulsive eaters are caused purely by organic problems.

/ /

d.

/ /

Feeding mental health patients is frequently a problem situation. Each patient presents a slightly different picture, but there are certain general problems the specialist encounters. Some of these problems are also met on medical wards, but you will discover more of them on the psychiatric unit, owing to the degree of anxiety experienced by the patient as well as disorders in thinking.

Patients may refuse to eat for several reasons. A few are:

Legitimate Factors. Patients, like you and I, are people. All people do not eat all foods - for various reasons. Dislike for certain foods should be taken into consideration when feeding mental health patients.

Religious beliefs are other factors the specialist should keep in mind when feeding the mental health patient. Although they are patients in the hospital, they can still practice their religion and their religious beliefs.

Allergies of the patient should be known by the specialist. Patients who are allergic to certain types of foods will not eat them; therefore, the specialist can determine why the patient is not eating.

When dealing with the older patient the specialist should keep in mind that the patient's poor teeth may be a factor for not eating.

Which of the following are legitimate factors why patients may not want to eat.

a. 1, 2, 4

b. 3, 4

c. 1, 3, 4

d. 1, 4

1. Allergic to certain foods

2. Indecision

3. Poor teeth

4. Religious beliefs

/ /

c.

/ /

Psychotic Factors. Delusions about food are common among mental health patients. The patient may feel that someone is trying to kill him, and that the food is poisoned. Patient will also believe that they do not have a stomach or intestines and can't eat. There is an abundance of delusions patients can develop. These are just a few.

Hallucinations may hamper the patient from eating. He may refuse to eat because he hears voices which command him not to eat.

In order to gain more attention from ward personnel, the patient may refuse to eat; therefore, focusing attention on himself, which will, hopefully, bring about action that the patient interprets as attention. Expect the patient to eat what is placed on the table before him. Do not be over attentive to his protests of dislike, occasionally let him miss a meal and most important do not focus upon his behavior.

Which of the following is a hallucination concerning a feeding problem.

a. A patient feels he is being poisoned.

b. A patient hears voices telling him not to eat.

c. A patient will not eat because he feels he has no stomach.

d. A patient does not eat because he is too active and feels he does not have the time.

// //

b.

//

Principles for Feeding Mental Health Patients. The following principles may be helpful when feeding mental health patients:

a. It is always helpful in making the patient feel more comfortable if he is among the other patients, so whenever possible, have the mental health patients eat together.

b. Having a pleasant environment helps the patient feel more like a person. The dining hall should be quiet and free from disturbances.

c. When feeding the mental health patients, the legitimate factors should be kept in mind when selecting diets.

d. At times it becomes necessary for patients to be spoon fed.

Sleep and Rest

The need for sleep and rest is a physical need that all human beings have. Individuals who go for long periods of time without sleep become irritable and nervous. They begin to lose interest in daily activities and finally might experience hallucinations.

For psychiatric patients sleep might become a problem. Depressed patients tend to have trouble sleeping. This is due to their constant preoccupation with their problems. Withdrawn patients use sleep as an escape and sleep all the time. Each requires a different approach and the specialist should be aware of the sleep habits of each of his patients.

People who go without sleep might experience

a. 2, 4 — 1. Nervousness

b. 2, 3 — 2. Hallucination

c. 1, 3, 4 — 3. irritability

d. 1, 2, 3, 4 — 4. Loss of interest in activity

/ /

d.

/ /

Depressed individuals tend to

a. Have night mares

b. Have trouble sleeping

c. Sleep constantly

d. Sleep well at night

/ /

b.

/ /

Sex

The word SEX denotes many things in our society. For some the word is taboo and not to be spoken about to the children; for others the word and the subject bring giggles and red faces of embarassment; while to others it is a word and subject which is talked about openly and maturely. Which ever way one fits into the above 3 areas all must agree that sex is important to all individuals.

Although sex is not purely a physical need it is being discussed here because certain aspects of sex do involve the physical portion of the body.

There are three primary purposes of sex; they are: (1) reproduction, (2) sexual pleasure, and (3) expression of love. The first two ways involve the physical portion of the body more than does the third reason.

Sex is purely a physical need.

True or False

/ /

False

/ /

People learn to act in particular ways concerning sex. No individual is born with the predetermined fate of being a rapist or a prostitute. The individual learns his sexual behavior from his family and from his peer group.

Why do people act the way they do concerning sex?

a. Inherited in the genes

b. Learned from family

c. Learned from friends

d. b and c

e. a and b

/ /

d.

/ /

For the patient that is mentally ill sex or the fulfillment of sexual desires and needs may become a problem.

For some patients there is a decline in sexual interest. This is very evident in the depressed patients. For some there is an over emphasis on sex; this is evident in the maniac or individual suffering from nymphomania.

Some individuals may experience a Homosexual Panic. This is a condition which is brought about by an individual being around only to members of his or her same sex for long periods of time. This occurs in places such as dormitories, barracks, or on wards in hospitals. Being around one's own sex for a long period of time might make an individual question whether he is homosexual or not. Most of these individuals are not homosexual and will never be, but they become worried about their sexuality. The specialist can help these people by explaining that this is a fairly normal occurrence in life and they would in time get over it.

Depressed patients are usually oversexed.

True or False

/ /

False

/ /

A homosexual panic is the first sign of a person becoming a homosexual.

True or False

/ /

False

/ /

Hygiene

These are the physical needs which are most obvious to the specialist working on the wards. This includes oral hygiene, bathing, hair care, and nail care.

Oral Hygiene. Cleanliness of the mouth and teeth is not only a preventive measure against oral cavity disease but definitely affects the general state of health and well being.

Routine oral hygiene is carried out following meals and before retiring. Whenever possible the necessary materials (brushes and paste) should be made available personally to the patient.

Very depressed, preoccupied, restless, or agitated patients often need guidance and assistance.

Fruit juices, milk, and other beverages offered at intervals will supply essential vitamins and minerals necessary for dental health. A light coating of the lips, gums, and inner-cheek membranes with one part lemon juice mixed with four parts mineral oil will prevent cracked tissues.

The major purposes of oral hygiene are:

a. 1, 2, 3, 5

b. 2, 3, 5

c. 1, 3, 4, 5

d. 1, 3, 5

1. Clean mouth
2. Improves concentration
3. Cleans teeth
4. Is a good evaluation tool
5. Prevents lip irritation

/ /

d.

/ /

Bathing. Bathing is important and should be practiced daily, whenever possible for the patient's comfort. If the patient does not bathe satisfactorily while under the shower, the nurse or specialist will have to substitute a tub bath with complete supervision. The closed area of the body (axillas and genitals) should be thoroughly cleansed to reduce body odors.

The specialist must also be aware of the patient with a cleanliness complex or compulsion who will repeatedly bathe himself until he is stopped. This type of patient will utilize considerable physical and psychic energy and must not be overlooked. The specialist may simply drain the tub and suggest that it is time for drying and dressing.

Acutely disturbed patients usually cannot be bathed according to schedule. The best plan is to carry out such measures at an opportune time, that is, when the patient is quiet and cooperative. It may be necessary for more than one specialist to bathe such a person.

The protection necessary during bathing consists of control of water temperature, and water level. Indirect but careful supervision of the patient throughout the procedure should be made.

Elimination

Every organism must eliminate its waste. Psychiatric patients may have difficulty urinating or may become constipated. Guilt about sex many times causes a patient to not be able to urinate. Constipation is produced on the psychiatric wards by a patient not eating properly or due to the medication. Elimination is the physical need which goes unnoticed most often on the psychiatric wards and so the specialist must be aware of these needs of patients.

Constipation is produced on a psychiatric ward mainly by:

a. 1, 2

b. 1, 2, 4

c. 3, 4

d. 1, 2, 3, 4

1. Poor diet

2. Medications

3. Drinking too much water

4. Guilt about sex

/ /

a.

/ /

Exercise

The human species needs to be active. Recently much emphasis has been placed on the need for exercise and how exercise helps prevent heart attacks.

Psychiatric patients do not exercise properly. They many times would rather sit and sleep rather than exercise. The specialist should get the patients involved with exercising to prevent weight gain and to prevent heart attacks.

Psychiatric patients do not usually like to exercise.

True or False

/ /

True

/ /

Only patients who do not bathe need to be supervised.

True or False

/ /

False - be aware of compulsive bather

/ /

Hair and Scalp

The threat of lice is ever present in large groups. Patients' hair and scalp should be inspected and shampooed regularly. A periodic time for such care should be designated and a check list devised so that no patient will be neglected.

Nails

Long, tapering nails should not be permitted. The patient may inflict personal injury upon himself and others. Attention should be paid to this factor during the admission procedure.

Pleasant commenting on how nice the patient would look or looks is a good approach.

Match each of the following with the correct answer.

____ 1. Hair and scalp   a. 1 part lemon juice & 4 parts mineral oil

____ 2. Nail care   b. lice

____ 3. Bathing   c. May inflict injury

____ 4. Oral hygiene   d. Reduces odor

/ /

1-b, 2-c, 3-d, 4-a

/ /

The reasons a patient should have good physical hygiene:

1. Represents a normal pattern of living
2. Helps avert complicating physical illness
3. Gives a patient a better chance for recovery
4. Increases self responsibility

Remember, one of the best ways to encourage good patient personal hygiene is to set a good example.

EMOTIONAL NEEDS

The second part of this workbook is concerned with the Emotional Needs that individuals have.

The way emotional needs are satisfied in our early childhood affects the development of our personality. If in our early years and throughout life these needs are satisfied, we become secure individuals with confidence in our relationships with others. On the other hand, if these needs are not satisfied, we become insecure and anxious individuals with feelings of inferiority.

Right attitudes toward your patients and fellow-man can be developed more easily if you understand the emotional needs of people. When you recognize and understand these needs you can understand human behavior more readily.

Acceptance

All persons have a need to feel accepted by other individuals in two way relationships, as well as by the member of a group. Acceptance does not always imply approval. At times the specialist may accept behavior which he does not approve. Accepting the patient's behavior, regardless of what it is like, will help him to realize this need. It can be therapeutic for the patient to be allowed to act out whatever he feels inclined to express, including his negative actions within the limits of safety to himself and others.

It is helpful for nursing personnel to try to develop the philosophy that, regardless of the patient's antisocial behavior, he has demonstrated a capacity to respond emotionally, which is often the first step toward recovery for some individuals. Once the patient's need to be accepted has been satisfied sufficiently, his behavior may change to socially acceptable relationships.

The specialist should accept the patient's behavior regardless of whether he agrees or disagrees with it.

True or False

/ /

True

/ /

Self-Esteem

People universally have a need to think well of themselves. Many persons have intense feelings of inferiority. Thus criticism tends to undermine a patient's morale and may lead to feelings of loss of self-confidence. To raise an individual's self-confidence the specialist may try to give honest praise in appreciable realistic terms.

Security

Maintaining consistency, giving reassurance, and setting limitations when necessary, all help to bring about feelings of security.

Maintaining consistency - the patient may react acutely to an absence of consistency in viewpoints and management of his behavior by the staff; the lack of consistency produces feelings of insecurity, and the patient is unable to predict what to expect. Thus, there should not be conflicts between staff members regarding the general approach to the patient.

Reassurance may be given in several ways, dependent upon the individual situation. The specialist may remain with the patient when he appears apprehensive and frightened. The specialist can transfer feelings of calm and confidence to the patient by remaining calm and confident himself in tension producing situations. It is also important to explain, before hand, to the patient what is going to be done, and to remember that patients want to have their questions honored regardless of how trivial some of these questions may appear to nursing personnel.

A major cause of lack of security in patients is

a. Setting limits

b. Giving reassurance

c. Reduction of tension

d. Lack of consistency

/ /

d.

/ /

Love

The need for love is so basic to all other human needs that supplying all of the other herein mentioned needs will automatically indicate our love for the patient. To express our love for another individual, it is essential that we avoid harsh criticism, but we use instead tactful suggestions. Positive and sincere facial expressions, gestures, and spoken word, communicates to the patient he is liked.

Understanding

The patient has a need to converse with others in a language he understands, and some times we may find it necessary to adapt our language to the patient's level of understanding. Also, we need to understand the patient's language and this is not always an easy task; a patient's conversation may be contradictory to what he is actually thinking and feeling. That is why it is important for us to be alert to the patient's feelings.

To understand, an individual must be able to empathize. This is different from the ability to sympathize, which occurs when the specialists' feelings are like the patients. To empathize requires that one be able to listen to the patient's expression of his conflicts, yet maintain an objective, emotionally detached viewpoint. In other words, a specialist may help the patient to feel that he is understood without becoming subjective.

Empathy means

a. Being subjective about a patient's feelings

b. Feeling the same as a patient

c. Feeling sorry for a patient

d. The same as sympathy

e. Listen to patient, yet maintain objective viewpoint.

/ /

e.

/ /

Being subjective means letting your personal feelings enter into your judgement of a patient.

True or False

/ /

True

/ /

Dependence

Some people have a greater need to be dependent than others. This need may become paramount when the patient finds problems of living too overwhelming. The longing to return to the dependency period, when little effort was required to obtain life's essentials, is not unusual. This may be expressed through passivity, demanding behavior, or somatic complaints. To reactivate feelings which were satisfied during infancy, when the complete needs of the individual were met by the mothering figure, may be essential for the patient's eventual recovery.

Independence

There are patients who have strong needs for independence. These are often individuals who have lived under authoritarian conditions, without choice in many matters. The order to satisfy this need, the ego, begins to assert itself. The need for independence may be expressed through aggression, negativism, and refusal of nursing attention. Meeting this need may sometimes be accomplished by the specialists showing respect for ideas offered by the patient. Such individuals should be encouraged to make decisions and assume responsibility for self-care within the limits of good judgement.

Dependence and Independence

We sometimes observe a dual need in patients who apparently foster a need for both dependence and independence. For example, the patient who has been rejected may develop over compensatory reactions by becoming independent of others for friendship. At the same time that the patient fears to make friends, he is inwardly desirous of companionship.

Patients with a strong need for dependence may exhibit which of the following behaviors. (circle all correct answers)

a. Passivity

b. Demanding behavior

c. Aggression

d. Negativism

e. Refusal of nursing attention

f. Somatic complaints

/ /

a, b, f.

/ /

Select the answers in Column A that best completes the sentence in Column B.

COLUMN A

1. Love
2. Dependency
3. Security
4. Acceptance
5. Independency

COLUMN B

a. Maintaining consistency, giving reassurance and setting limitations when necessary, all help to bring about feelings of ____________________________.

b. ____________________________ is a feeling of belonging.

c. So basic to all other needs, that supplying all of the other needs will automatically indicate our ____________________________.

d. The need for ________________ may be expressed through aggression.

e. ________________________ may become paramount when the patient finds the problems of living too overwhelming.

/ /

1-c, 2-e, 3-a, 4-b, 5-d.

/ /

SOCIAL AND CULTURAL NEEDS

When a patient is emotionally and physically comfortable, his social and cultural needs then become the prime influence on his behavior.

Social and cultural needs provide the patient with the material means for adjusting to his environment. These needs are a significant factor in the development of the personality in that they stimulate particular interests and provide socially acceptable forms of activities, as well as values, for desired forms of behavior.

Basically, there are three social and cultural needs. These are the needs for security, social approval and achievement. Each will be examined in more detail below.

Security

The social and cultural need for security is reflected in the common preference for jobs, in Social Security Legislation, in insurance against disability, and in society's emphasis on law and order.

Feelings of insecurity may have widely differing effects on behavior, but typically they lead to a restriction in activities, to fearfulness and apprehension, and to failure to participate fully in one's world. As a consequence, the individual is denied many enrichments and growth experiences.

Security is the feeling of being able to hold on to what one has, of being sure that he will fare as well in the future as in the past.

War or the threat of war is to be taken into consideration to feel a sense of security. Although wars have sometimes been necessary to achieve or maintain freedom and human rights, the condition of warfare has placed great stress upon large numbers of people.

Today most of mankind lives in fear of the new and incredibly destructive instruments of modern warfare--chemical and bacteriological.

Fear growing out of this threat has led some of us to overaggressive attitudes, intellectualization, and apathy.

Security is the feeling of being able to hold on to what one has.

True or False

/ /

True

/ /

Achievement

Striving toward fulfillment or achievement takes different forms with different people, depending upon their abilities, values, and life situations. Fulfillment striving may take the form of being a good wife and mother, of writing poetry, or other activities that lead to personal growth and add meaning to one's existence.

Satisfactory employment is an important source of economic well-being and feelings of self worth and achievement. Perhaps nothing adds more to a man's sense of competence and to the meaningfulness of his life than work that he does well and is of value.

There are many people today who face serious occupational problems. Older people who are still productive are being forced to retire at a specified age, or a specified number of years with a company or organization.

They must adjust to a reduced income and the feelings of being no longer useful. Many young people today--especially unskilled and semi-skilled workers -- are being replaced by automation. Such happenings bring both physical hardships and self-devaluation. Many young people who lack technological skills, are either unable to find employment or forced to accept jobs which they consider unsatisfactory. Imagine how unpleasant it would be to see your future as dull and unfulfilling.

What are some conditions which might hinder a person's achievement. (circle all correct answers)

a. Age

b. Automation

c. Lack of knowledge

d. Lack of skills

/ /

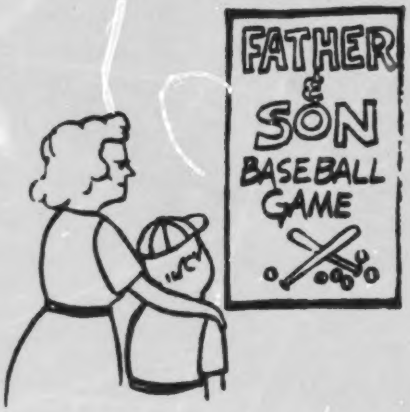
a, b, c, d.

/ /

Social Approval

All life involves change--we grow up, marry, have children, shift social roles, face death of a parent, undergo operations, and adjust to numerous minor changes as we go through life. Changes need not cause difficulty. However, rapid social change has created serious problems for some people. These changes leave the person feeling alone and distressed, as in the case of a death of a parent. Feelings of aggression are brought about when a person does not accept the changes, and tries to fight them.

Family stability has a major role in the adjustment of an individual. Divorces and family conflicts lead to needs not being met. Such as, "Billy does not have a father" or "Billy's mother does not want to come to P.T.A." This brings about feelings of loneliness and rejection from this boy.



More personal factors of status to consider are, physical appearance, sex, age, intelligence, special abilities--which influence our status in society and are an essential part of our self-evaluation. Personal characteristics which are admired by our group are valuable assets that increase feelings of adequacy and self-esteem, and on the other hand, lead to self devaluation. Here too, we tend to compare ourselves with others, and few of us find such comparisons highly satisfactory. We are likely to be acutely aware of our big nose, freckles, or other alleged inferiorities while we ignore and fail to make the most of our assets.

When a person cannot accept rapid social changes what feelings might arise?

a. Apathy

b. Fulfillment

c. Aggression

d. Security

/ /

c.

/ /

Personal appearance is always a source of feelings of adequacy for an individual.

True or False

/ /

False

/ /

Our modern society is composed of complex blends of many individuals all with the same basic physical, emotional, social and cultural needs. Patients too have these needs and one of the major tasks of the specialist is to help the patient to meet these needs. Not helping the patient meet these few needs may result in the following:

a. Mental illness encourages regression, and dependency, accompanied by a rise in the anxiety of the patient.

b. Lack of knowledge as to the outcome of illness may provoke negative response.

c. The patient may be overwhelmed by the cooperative efforts of medical personnel.

d. Childish, helplessness can be gratifying to the patient.

e. Resistance to hospitalization.

f. Temporary separations from one's immediate social group can provoke feelings of distress.

This workbook is now complete. Review this information and ask your instructor for the test on this material.

10-2

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STUDY GUIDE 3ABR91431-2-I-5a
June 1975

STAGES OF PERSONALITY DEVELOPMENT

OBJECTIVE

Describe the structures and stages of personality development.

INTRODUCTION

The development of a personality is an interesting and extremely important aspect to the understanding of mental illness. When one sees a man who can no longer function in society and at the same time, one realizes the assumption by Sigmund Freud that the events of infancy to age six are the major foundations of adult personality, one can readily understand the vital importance of a personality development.

As a Psychiatric Ward Specialist, you will be working with many types of personalities with varying degrees of abnormality. By understanding the personality developmental process and the significance of heredity and environment upon the personality, you will be better able to understand and assess the personality of the mentally ill person with whom you are in contact.

Read chapter 12, "Personality Development," *Textbook for Psychiatric Technicians*, pages 171-183 and answer questions at the end of the textbook prior to class.

INFORMATION

1. STRUCTURE:

Many theories have evolved about the development of the personality. For instance, Carl Jung saw the personality development in three stages, all centered on the term libido which referred to the general energy of life. Each stage characterized the direction of the libido. Other concepts like Adler's concept of "life style" or Fromm's concept of the alienation of men in a vast impersonal society, have taken their place in personality theories. But, certainly one of the most logical and generally accepted theories of personality development was described by Sigmund Freud.

This supersedes SW 3ALR91431-I-5a, August 1974.

Designed for ATC Course Use

DO NOT USE ON THE JOB

To start our journey into the making of a personality, let's start with the parts of the personality which are found in a concept called the mind or psyche. The mind, like other organs, possesses its own form and function. It reaches all parts of the body and also serves to adjust the total organism to the needs or demands of the environment.

Your mind is divided into levels of consciousness: the conscious, the preconscious (subconscious) and the unconscious. As an example of these, imagine a narrow beam of light shining from a flashlight into a room. In the beam itself you can see clearly. Just at the edges of the beam of light things can still be seen but are dim and not too easily recognized. Beyond these dim edges is the darkness. This will give you some idea of the concept of the levels of consciousness. With the conscious part of the mind represented by the bright part of the beam, the preconscious part of the mind by the dim edges and the unconscious part of the mind by the darkness.

(1) The conscious - forms only a very small part of the whole mind. Only a little of our mental activity goes on here. It is the part of our mind we see at work.

Example: If you are awake right now you are aware of yourself, your feelings, thoughts and sensations of what is going on around you.

(2) The preconscious (subconscious) - this is the dim shadowy region of half remembered and half forgotten things. Material collected here can usually be recalled without too much difficulty.

Example: It is the part of the mind in which you drag out old stories when you are reminiscing with the boys in the barracks at night - stories - things you haven't thought about in years.

(3) The unconscious - this is the part of the mind which contains that vast storehouse of memories, experiences and emotions which we cannot recall except under specific conditions. The largest part of our mental activity takes place here and many evidences of this can be seen in our speech, actions and reactions.

Examples:

(a) Slips of the tongue are rather common signs of unconscious material getting out into our conscious speech.

(b) In mentally ill patients we see unconscious thoughts, wishes, and impulses coming out in hallucinations, delusions and many other symptoms.

Freud took the mind a step further and broke it into three basic parts: Id, Ego, and Super Ego.

(1) The Id.

The Id is present at birth and knows nothing of reality or morality. It seeks only to gratify instinctual drives, to enjoy the pleasure that results when tension aroused by body needs is discharged. It wants satisfaction and does not care how it satisfies its demand. Included in it are two natural or instinctual forces:

(a) To love and be loved instinct - impulses include those whose aim is the production of pleasurable sensation such as pleasure from stroking the skin, urinating, moving bowels, as well as from sexual intercourse.

(b) To strike out aggressively instinct - impulses include those expressed both in activity and in fantasy, such as simple acts like sucking and wishes to murder and destroy.

The above two instinctual forces are constantly seeking expression in the outside world in an effort to lessen the inner tensions felt as a result of their pressure. These forces are almost entirely unconscious and only occasionally reach conscious awareness. But they do effect every thought, feeling, fantasy and other action of the human being, although they are also changed and influenced by the other structures of the mind.

(2) The Ego

The Ego is the name Freud gave the portion of the personality that acts as a go-between for the Id and the outer world. The Ego keeps our behavior within social limits. The Ego decides which Id impulses will be satisfied and which will not. It is the center of memory and the controller of much voluntary activity. In early life the Ego is weak and cannot handle the Id, but as the personality develops the Ego is strengthened if supported from the outside (the parents) and assumes control of the personality to bring it to adulthood.

(a) Functions of the Ego - one of the functions of the Ego is "reality testing." It alters the instinctual impulses of the Id so that they can be expressed in an acceptable way in reality and yet remain capable of reducing tension within and provide the individual with a sense of satisfying pleasure.

(b) Example: If an individual sees himself as being unloved his Id impulse will be expressed so as to fit in with that idea of himself. Aggressive impulses might then be directed against all those who appear not to love him in the form of hostile and revengeful behavior or he may direct them into great strivings for success on the job. In the first case, the Ego is not functioning too well in terms with reality since we have seen how hostile action often produces hostile reactions and thus increases the feelings of being unloved. In the second case, the Ego is working more in agreement with reality since ambition and striving and success on the job do require some rewards in our culture.

(3) Superego

The third part of the personality is called the Superego and contains the unconscious control of right and wrong. These ideas are largely picked up from the parents of the child and dictate the child's later behavior in society. The Superego may punish trespasses on its territory by making the person feel guilty. This is its weapon. The healthy Superego keeps the personality within the bounds of moral society, yet is not rigid and allows adequate Id satisfaction. The Superego corresponds roughly with what we call conscience. Many people speak of a still small voice or the "eye of God" when they are actually speaking of the Superego. Mentally ill patients sometimes will put in their drawings an eye which actually represents the Superego. The Superego is concerned with morals, precepts, standards and ideals.

2. Stages

Freud viewed personality development as the organization and expression of basic sexual energy, or libido. Later the term libido was commonly used in a more general sense to refer also to the energy of the aggressive drive in man. The organization and expression of the libido theory of sexual development is seen in five stages starting at birth through adolescence. These stages are descriptive and can be observed in the growing child. The age limits defined will not, of course, hold true for every child and a child may show traits of more than one developmental stage at one time. However, the characteristics of one stage will usually dominate his behavior and so this division has value for understanding personality development.

a. Birth and Infancy (one year)

In the period of life beginning with birth and extending through the first year the infant's needs are largely satisfied through the oral intake of food. This is the reason for calling this period the Oral period. Nutritional needs and the hunger desire are satisfied in this manner in early life and contentment and security are felt by the child after feeding. The mouth is the principle pleasure zone and the behavior of sucking gives the infant his greatest pleasure. The infant looks particularly to his mother in this period for love, nutrition, and all the things that lead to an inner feeling of security. It is very important for the mother to realize this and provide these needs. If this is not done the initial personality of the child will be distrustful and pessimistic and lead to a demanding, insecure adult personality. The infant displays behavior that works solely on the pleasure principle (seek pleasure to avoid discomfort). In other words, when the infant is ready to eat, he will not wait, but will start demanding food. Or when the infant has to urinate, he will not wait until he is placed on the commode, but will do it in his pants. He wants what he wants when he wants it.

b. Childhood (two-twelve years)

The childhood of an individual is divided into three parts, the first one being early childhood, age 1-3. The early childhood stage of development Freud termed the Anal period. The infant has come to get pleasure out of retention and expulsion of feces and urine. The membranes of the anal region presumably provide the major source of pleasurable stimulation. Now a certain amount of obedience becomes expected of him, in the form of toilet training. This is a trying period for a child and adult alike. By and large it depends on the value the child places on the love and affection it receives from the mother on how rapidly it will conform to her wishes. In return for continued love, the child is willing to give up the pleasure of control of its feces and urine for the artificial control dictated by the mother. Stubbornness and ambivalence are normal characteristics of this period. If this period is not handled correctly, shame, disgust, and inferiority may become a permanent part of the child's personality. In adult life he may be aggressive and compulsive to compensate for this defect.

The next stage of childhood is referred to as middle childhood, age 3-6. This stage is usually well separated but may last a varying period of time according to how well the child adjusts to the peculiar problems here. This period is called the Phallic period. The pleasurable sensations are discovered arising from stimulation of the genitalia and masturbation is frequent if not universal. This does not carry the adult connotation, however. During this period the child recognizes his sex and its difference from the opposite sex and also recognizes that his parents are of opposite sexes. Children in this age are intensely interested in sex and birth and ask numerous questions concerning this problem. His behavior now is much more reality orientated and the reality principle of behavior is identified. Actually, the reality principle has started formulating back in the Anal Stage, as seen in the situation of a mother trying to teach toilet training. The child learns that instead of urinating in his pants when he wants to (pleasure principle) it is better (and his mother appreciates it more) if he holds off this urge and does it in the commode. (Reality Principle) By this stage the reality principle is very identifiable in that the child is toilet trained and has learned to restrain desires until an acceptable time. Also, in this stage we find a conflict each child goes through, called the Oedipus Complex. In this the child feels a new attraction to the parent with more implications than a demand for love and security. He is attracted because of the difference in sexuality. As this attraction progresses, the parent of the same sex becomes a threat to security as he is now a rival. Thus, there are jealous as well as warm feelings toward the parent of the same sex and ambivalence, confusion and sometimes fear results. This complex is repressed in the unconscious, but the confusion and fear of the parent of the same sex may be seen in the form of nightmares about animals or a man that is going to get the child. As time passes the child soon realizes he may not continue to progress in a sexual relationship with the parent of the same sex and when he grows up he may marry as well as this parent did.

TATTOOING
MOTHER

"HOW'S THAT, OEDIPUS?"

For example, a young boy starts identifying with his father and may make the statement that when he grows up he would like to marry someone just like mother.

This process of identifaction brings us to the next stage of development found in later childhood, ages 6-12. This phase was called by Freud the latency period of development. In this phase the child participates actively in all types of behavior common to his sex. In this phase also there is relatively little that can be termed sexual behavior, hence the name latent period. The child becomes preoccupied with developmental skills and activities. The youngster likes to imitate heroes of his sex as Hopalong Cassidy for boys, or Florence Nightingale for girls. Activity involving both sexes is rare and the curiosity of the child in this age is unlimited. For this reason, education is begun at this time. The child learns at an amazing rate due to his insatiable desire for knowledge of the surrounding world.

c. Adolescence (thirteen-twenty-one years)

With puberty and adolescence come new problems. However, these problems are largely concerned with the change over from childhood attitudes to adult attitudes. This period is called the genital stage, because of the heterosexual relations. There are times of great psychological stress in this period and it requires a personality with a firm foundation from previous development to sail smoothly through this developmental age. Four things are accomplished in this period: breaking away from parents; choice of a vocation; acceptance of heterosexual goals; development of the personality toward society. In looking at this adolescent period we see that it is not accomplished in a short period of time and takes a wide variety of experiences to let the child literally grow into adulthood. The parents at this time must be understanding and willing and ready to relinquish authority as the child demonstrates that he is ready for more independence. After this period the child has become an adult and should possess an adult personality. The personality goes on developing in adult life as the adult realizes ambitious goals of raising a family and so forth, but the major part of the personality development is past. If this development has been sound and progressed normally, the adult will lead a mentally healthy life; whereas, if it has not, he is liable to deteriorate mentally with excessive stress.

Now that you have studied one main theory of personality development you can more readily see the importance and significance parents have in the destiny of their children. Keep in mind that no matter whose theory of personality you study the goal of each is to produce a socially approved, heterosexual, motivated individual.

You are now ready to take the criterion progress check subject material.

PT-3ABR91431-2-1-6A

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

ADJUSTIVE REACTIONS

June 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

PT 3ABR91431-2-1-6a
June 1975

ADJUSTIVE REACTIONS

OBJECTIVE

Describe adjustive reactions and their effects on behavior.

INTRODUCTION

Vital to your understanding of the reasons behind human behavior is a working knowledge of the ego defense mechanisms. As you work through this program of instruction, you will learn about the various defensive techniques employed by all of us to protect our self-image and reduce or prevent anxiety. A word of caution: although the ego defense mechanisms are treated here as if they were distinct and separate, in reality, they are frequently used in combination, and elements of one mechanism will often be found in others. This is especially true of the mechanism of repression, elements of which are found in all true defense mechanisms.

Essential to your understanding of defensive techniques is the concept of appropriate (normal) and inappropriate (abnormal) usage. Generally speaking, a defense mechanism is said to be appropriately used when it contributes to the overall process of personality adjustment and allows the individual to maintain a balanced level of functioning and effectiveness. A defense mechanism becomes inappropriate when it is used continually in an exaggerated and rigid manner so as to interfere with effective personality adjustment.

INSTRUCTIONS

The following pages contain a unit of instruction in the form of a program. This program is designed to give you information about some of the more commonly used ego defense mechanisms. You will receive small amounts of information accompanied by a request that you make an active response through answering a question or completing a sentence. The correct answer is given to the right of the frame immediately following.

For example:

1. Your present frame question.	
2. Next frame.	Desired response

Keep each answer covered until you "test" yourself by trying to make the desired response. The program will move you ahead in a logical progression.

This supersedes PT 3ABR91431-I-6a, January 1975

1. Criterion Test

You will be tested on the contents of the program to determine how much of the material you were able to learn. Your criterion test will be administered immediately.

Turn page and begin your program of instruction.

1. An ego defense mechanism is an unconscious mental device used by a person to protect his self-esteem or self-image; that is, to enable him to see himself as a worthwhile individual. An unconscious mental device used to protect one's self-image is known as an ___ _________ _________________.	
2. Ego defense mechanisms are also known as "mental mechanisms" and "mechanisms of adjustment." Through their use, a person adjusts to the anxieties and frustrations of life which threaten his sense of adequacy or security. Mental mecnanisms, or mechanisms of adjustment, are unconscious in nature. They are also known as ___ __________ ______________.	ego defense mechanism
3. The ego is really the sum of one's defense mechanisms; that is, all of the defensive techniques one has learned to use in order to cope with frustrations and anxieties of life. Thus, the ego defense mechanisms act as cushions to protect us from the frustration and anxiety which threatens us as we seek to come to terms with our emotions and with the forces of society. Ego defense mechanisms help us to cope with the conflict between our emotions and the forces of society. TRUE ______ FALSE ______	ego defense mechanism
4. Remember that ego defense mechanisms are unconscious in nature. Thus, they are used without the user's awareness unless someone makes the user aware that he is using them. Until someone tells him, the person using a certain ego defense mechanism is unaware that he is using it. TRUE ______ FALSE ______	TRUE

5. To summarize: Ego defense mechanisms are mechanisms of adjustment, or mental devices, used unconsciously by everyone when our self-images or self-concept is threatened by our emotions or by the forces of society.	TRUE
6. Since everyone uses ego defense mechanisms, their use is considered normal unless they are used so extensively or inappropriately that they produce clinical signs and symptoms which indicate that the person may be suffering some form of emotional or mental illness. Most people use ego defense mechanisms in a so-called "normal" manner. TRUE ______ FALSE ______	No response Necessary
7. If a person used a certain ego defense mechanism so extensively and inappropriately that he evidences clinical signs and symptoms indicative of a mental illness, we may say that he is using the ego defense mechanism in an ____________________ manner.	TRUE
8. For the remainder of the program, we shall study some of the more commonly used ego defense mechanisms. Through the study of the specific mechanisms, you will gain an insight into some of the causes of human behavior. You will remember that you have already been taught that most behavior is learned; it does not just happen. Thus, a person learns to use certain ego defense mechanisms, and their use becomes a part of his behavior.	Abnormal (unhealthy)

9. The first ego defense mechanism that we shall study is called indentification. Identification is a defense mechanism, operating unconsciously, by which a person patterns himself after someone he admires. Every child identifies with adults or with other children as he matures. It is most important that his models be well-adjusted people. If a child uses well-adjusted models, he is making an appropriate (healthy) use of the defense mechanism known as ____________________.	No response necessary
10. It is very important that the child identifies with a well-adjusted model in his environment as he becomes increasingly aware of his social world. For example: If a boy has a good father with whom to identify, chances are that he will not identify with a criminal. The boy who patterns himself after a good father is using the defense mechanism called __________ in a healthy, wholesome manner.	identification
11. Here is another example of the healthy use of the mechanism known as identification. A girl identifies with, or patterns herself after a woman who is a good wife and mother. This girl will probably grow up with a healthy self-image of herself as a well-adjusted female. The defense mechanism by which an individual unconsciously patterns himself after another is called ____________________.	identification
12. Remember, identification, like all of the other defense mechanisms, is an unconscious process. Thus, it differs from ordinary imitation; imitation is consciously accomplished. Identification is an ________________ process.	identification

13. Identification, as you can see, is very important in social and emotional adjustments. If a child has well-adjusted people around him with whom to identify, he will learn to use identification in a ________ manner.	unconscious
14. Some children grow up in a faulty environment and develop their self-image in the company of poorly adjusted older people. These children learn to use the defense mechanism called identification in an _________ manner.	normal (healthy)
15. Another common ego defense mechanism used by all of us on occasion is called projection. Projection means blaming someone else, or something, for one's own failings and guilty feelings. "Pot calling the kettle black" is a good way to describe the defense mechanism known as ____________, whereby we blame another for our own shortcomings.	abnormal (unhealthy)
16. A good way to remember projection is to think of a movie projector. When using a projector, you project the image away from you and onto a screen in front of you. When you use the mental mechanism of projection, you unconsciously attribute feelings or attitudes, unacceptable to you, onto someone or something else.	projection
17. For example: A student blames the teacher for his poor grades. The student cannot admit that he is unable to absorb the material because this would damage his self-image of himself as smart. He is unwilling to think of himself as stupid. The defense mechanism whereby one attributes to others, the failures and guilty feelings that are really his own is known as ___________.	No response necessary

18. All of us use projection at times. We even project onto harmless things. For example: A man stays out too late and as a result, does not hear the alarm clock in the morning. He says the alarm is defective. This illustrates the use of projection to avoid social disapproval or punishment that would cause embarrassment, anxiety, and loss of self-esteem. Projection is the mental mechanism by which a person attributes his mistakes and unacceptable thoughts or desires to his external environment. TRUE ______ FALSE ______.	projection
19. You can readily see that if a person uses projection continually, it could become a way of life and prevent that person from seeing himself as he really is. For example: A lazy soldier does poor work and finally his superior becomes annoyed. The soldier will not admit to himself that he is a good-for-nothing; that would damage his self-image. Instead, he says the sergeant "has it in" for him. The above example illustrates the use of the defense mechanism called __________________.	TRUE
20. Let us carry the above example to an extreme degree. Suppose the failure to face the reality that he is lazy and a poor worker becomes habitual with this young soldier. Pretty soon, he feels that everybody is against him. After a while he hears "voices" coming from the ventilator. The "voices" call him names. We know that the voices are actually coming from within the soldier, but he cannot face the reality that he is actually calling himself names because of his own feelings of guilt. It preserves his self-esteem to perceive the voices as coming from his external environment.	projection

21. This example of a soldier who heard voices is an example of the abnormal use of the defense mechanism called projection. Projection is of particular importance to those who work with the mentally ill because it is the basic mechanism used by those patients who feel they are being persecuted by others. You will learn more about this mechanism of projection later in your course. Projection is one of the most important of the defense mechanisms to those in the psychiatric field. TRUE ______ FALSE ______	No response Necessary
22. In summary: Projection is the defense mechanism by which one blames someone or something for one's own emotions or failings. Psychiatric patients who feel that they are being persecuted by others are projecting their own hostile ideas and suspicious feelings because they cannot face the fact that they have those ideas and feelings. You are not a psychiatric patient; therefore, you never use the mechanism of projection. TRUE ________ FALSE ______	TRUE
23. The next ego defense mechanism for us to consider is known as denial. Denial is the unconscious refusal to face unpleasant reality. For example: A person puts off doing work (procrastination) because he unconsciously fears that he may fail at it. Since he refuses to face the unpleasant reality that he may fail, he is using the mechanism called ______________________________.	FALSE

24. Denial is the ego defense mechanism by which the person unconsciously protects himself from unpleasant aspects of reality by simply refusing to face them. Denial, then, is plain, ordinary rejection of painful reality, and we all use this mechanism at times. Unless denial becomes "a way of life," or a characteristic way to avoid unpleasant reality, its use is considered to be within ___________ limits.	denial
25. A person with a major mental illness may completely reject the real world by unconsciously denying its existance. When a person unconsciously resolves emotional conflict and allays anxiety through the use of denial to such an extent that he loses contact with reality, his use of denial may be said to be _____________.	normal
26. Denial is escapism. Through its use we escape recognition of painful reality. Unpleasant situations are thusly ignored or avoided. Here is another example of denial: A mother refuses to accept the fact that her child is mentally deficient. Which of the following illustrates the use of denial? a. A person claims that he did not get promoted because his boss dislikes him. (All of his co-workers know of his inefficiency). b. An old man claims that he is still able to do everything that he could when he was young.	abnormal
27. You, as a nice, normal person, have no need to use the mechanism of denial. TRUE ______ FALSE ______	Answer -- b. (a. illustrates projection, not denial.

28. Commonly confused with the mechanism known as denial is another mechanism known as repression. Repression is the defense mechanism which banishes unacceptable ideas, affects, or impulses from consciousness, or refuses to admit them to the consciousness. The defense mechanism by which an individual excludes painful thoughts or desires from his consciousness without being aware of doing so is called ______________.	FALSE
29. Although repression is carried out unconsciously and automatically, the individual's conscience (super-ego) helps to control this mechanism. For example: Your brother brings home a new wife, and you fall in love with her. Your conscience will not allow you to admit the fact. Unconsciously, you repress your love. It never is allowed to enter your consciousness. It may turn up in a disguised form, such as a dream. For example: You may dream you are rescuing your brother's wife from danger.	repression
30. Here is another example of the use of repression. A boy gets so angry at his mother that he has the urge to strike her; his conscience intervenes and sees to it that the urge never gets into the boy's consciousness. This protects him from hitting his mother and having to deal with a guilty conscience. Do all people repress their threatening impulses to some degree or other?	No response necessary (That frame gave you enough to think about!)
31. Forgetting is involved in the mechanism of repression. A soldier who sees his best buddy killed may develop an amnesia for this experience. Do you think that this is an example of repression?	YES

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32. A person with amnesia has forgotten an incident or situation too painful to keep in one's consciousness, or admit to the consciousness, so the soldier mentioned above did repress the sight of his best buddy being killed before his eyes. A child witnesses the murder of his mother by his father. When questioned, he seems to have no remembrance for this event. What is the defense mechanism at work in this case?	YES
33. Although, in repression, the painful experience or thought, is not permitted admission to consciousness, it has not gone beyond recall. Hypnosis, or other techniques which put the person in a relaxed, semi-sleep state, might be used to "dredge-up" the experience and bring it into the person's consciousness. Only an experienced physician should attempt such a technique. TRUE ______ FALSE ______	repression
34. Another way a repressed event or thought may "come to the surface" of the mind is in the form of a symbolic dream. Thus, the event or thought is symbolized or disguised, so as not to be disturbing to the person. We are able to put many painful experiences out of our minds, so to speak, by use of the defense mechanism called ______________________.	TRUE
35. As with other defense mechanisms, repression could be used to an exaggerated degree, and the individual could habitually "forget" all anxiety provoking experiences. Do you think this would be a normal or abnormal use of repression?	repression

36. Repression is not to be confused with supression. Suppression takes place at a conscious level. Thus, a person could decide to work so hard that he would not have time to think about a disappointment or bereavement. Suppression, therefore, is a conscious mechanism. Repression, like other true defense mechanisms, is accomplished at an ________ level of awareness.	abnormal
37. Rationalization is a defense mechanism by which a person justifies his behavior, or gives socially acceptable reasons for his behavior in order to preserve his self-esteem or self-image. Since rationalization is a defense mechanism, a person ordinarily does not rationalize his behavior consciously, but, rather, _________.	unconscious
38. An easier way to define rationalization is that a rationalization is the finding of a logical reason for doing something you want to do. For example: A woman buys a dress that is too expensive. She excuses this by saying that it is important to keep up appearances for the sake of her husband's position. Thus, the defense mechanism whereby one finds a logical, socially acceptable reason for doing the things one wants to do is called. ______________________.	unconsciously
39. In the example given above, the woman unconsciously used the mechanism of rationalization to avoid the feeling of guilt which would have been intolerable to her if she had admitted to herself that she really wanted the expensive dress for her own gratification. Do you think that everybody occasionally uses rationalization, or only people like the woman in the example?	rationalization

40. Rationalization is really self-deception. If you know that you have to study for a test, but "sell yourself" on the idea that it would be better to go to a movie and relax, you are employing the defense mechanism known as ______________ in a classical manner.	yes everybody (The example was not at all unusual.)
41. Rationalization can lessen disappointment when desired goals cannot be reached. The old fable, "The Fox and the Grapes" illustrates rationalization. When the fox found that he could not reach the grapes, he rationalized his disappointment away by assuring himself that he really did not want the grapes anyway because they were probably sour.	rationalization
42. Although rationalization is used frequently by most of us, its use can be carried to extremes. Then its use is no longer within normal limits. The excessive use of rationalization may lead to delusions (fixed, false beliefs) in some mentally ill persons. When rationalization is carried to extremes, its use is considered to be ________________.	No response necessary
43. Here is an example of rationalization carried to an extreme. A man in a mental hospital refused to go outside the gates because he had the fixed, false belief (delusion) that his wife's relatives were outside waiting to kill him. This delusion persisted for years. Through its use, the man excused his inability to cope with the outside world. He was making exaggerated and extreme use of the defense mechanism known as ________________.	abnormal

44. Regression is a defense mechanism by which a person attempts to solve problems by going back to behavior which was appropriate when he was less mature. A child who begins to wet the bed again after the birth of a little sister or brother is using ____________________.	rationalization
45. Regression is a retreat from the trials and tribulations which are confronting the individual at the present time by simply reverting or going back to a state of emotional development when life was not so complicated. If a lonesome, young soldier, away from home for the first time, begins to cry "like a baby", he is using the mechanism of ____________.	regression
46. All people use this mechanism on occasion, when under stress; they resort to what we call "childish behavior." Thus, they may cry or even have a mild temper tantrum. When the mechanism of regression is used occasionally to relieve tension and anxiety we need not concern ourselves too much. TRUE ______ FALSE ______	regression
47. When a grown man or woman constantly indulges in childish, inappropriate behavior, the mechanism of regression is being utilized in an abnormal way. The ultimate form of regression is exemplified in the very mentally ill patient who curls up in the position of the unborn child in the womb (fetal position). The attempt to solve one's problems by going back to a less mature level of development is known as ________________.	TRUE

48. Fantasy (phantasy) is a defense mechanism by which the individual gratifies his wishes through imaginary events. Fantasy may be described as daydreaming. Everybody daydreams at times. A substitute on a football team may sit on the bench and daydream about entering the game and becoming a star. You may hate your first sergeant. You sit and indulge in the fantasy that he gets into trouble and gets "busted down" to buck private. This daydreaming is the defense mechanism known as ________________.	regression
49. You can see that when the defense mechanism called fantasy is used to escape temporarily from a stressful (anxiety provoking) situation, its use is within normal limits. Fantasy can be used productively to solve immediate problems, as when it is used in creative imagination. It can also be used productively to stimulate one to achieve desired goals. If the football player sitting on the bench likes the fantasy of himself as the star of the team so well that it spurs him on to greater efforts, the defense mechanism called fantasy has been used ____________________.	fantasy (phantasy)
50. Suppose, however, that the substitute football player begins to make fantasy his "way of life." He sits at home smiling to himself and even bowing to the right and left as if responding to applause. He is using the defense mechanism called ____________ in a nonproductive or abnormal manner because he is using it as an unrealistic substitute for true achievement.	productively

51. Compensation is a very useful defense mechanism. Compensation is the mechanism by which a special ability or trait is developed to make up for an inadequacy which may be real or imagined. For example: A homely girl may compensate for her handicap by developing a charming personality. Another example: A boy who is physically weak may develop into a fine scholar. The defense mechanism by means of which an undesirable trait is minimized by the exaggeration of another desirable trait is called ____.	fantasy
52. When the defense mechanism called compensation is used to overcome a handicap or defect through the development or emphasis of other traits, and when compensation is used to further achievement and meet wholesome competition, its use is productive and normal. Which of the following is an example of compensation? a. A girl feels that she cannot compete with her more attractive classmates, so she sits at home and daydreams that her "Prince Charming" will come to her. b. A girl with ugly legs takes great pains to have the most beautiful hair in her class.	compensation
53. The examples of compensation given so far have been of the sort which would have social approval. Compensation, like other defensive techniques we have studied, could also be used in an abnormal or pathological manner. Then, its use would not be socially approved. For example: A very small man becomes a ruthless bully and leader of a mob. He has developed leadership abilities to compensate for his small stature, but the development has been ________________.	Answer -- b. (a. Illustrates the use of fantasy.)

54. Displacement is a defense mechanism by which the individual discharges pent-up emotions that he has about a person or object, to a different, less threatening person or object. For example: A child misbehaves and is spanked or scolded by his mother. He reacts to this turn of events by striking his younger brother or destroying a toy. The thought of striking his mother may have occurred to the child, but this would mean loss of love and possible retaliation. Unconsciously, he elected to displace his feeling on a less threatening person or object. The defensive technique typically involving discharge of aroused feeling towards a neutral or less threatening person or object is called ____________________.	abnormal (unhealthy)
55. Displacement, used occasionally, has considerable adjustive value. It allows the individual to rid himself of dangerous emotions without fear of retaliation or loss of love. However, this mechanism, like others we have discussed, can be used abnormally or inappropriately. For example: A young soldier develops a strong hatred for his platoon sergeant and fears that someday he will kill him. To counteract this feeling and relieve his fears, he develops a morbid dread (phobia) of handling his rifle or bayonet. He has displaced his feelings and fears on objects symbolic of death and killing. People who develop a morbid dread (phobia) about persons or objects are using the mechanism of displacement in an ____________ manner.	displacement
56. Earlier in this program we discussed the mechanism or repression and said that it was an unconscious effort at excluding painful material from the consciousness. Another mechanism used by people is called reaction formation and reinforces repression by developing feelings and attitudes that are opposite to the ones unacceptable to the individual or his society.	abnormal (inappropriate)

Generally speaking, reaction formation is the building of emotional barriers to prevent our real desires or attitudes from being displayed in unacceptable behavior. For example: A young man is basically hostile; to act on his feelings of hostility would bring social disapproval; thus, he may react to his feelings of hostility by becoming very kind and solicitous towards others. In our example, the young man has ___________ his unacceptable feelings of hostility with the aid of _____ _______, and has preserved social approval by developing an attitude opposite the one he really feels.	
57. Reaction formation has adjustive value, but as is true in other mechanisms, is self-deceptive and may complicate an adequate adjustment if used inappropriately or excessively. A person may use reaction formation so extensively that it results in an exaggerated and rigid attitude which makes it difficult for the individual to maintain the flexibility necessary for a good adjustment and lead to excessive harshness or severity in his relationships with others. For example: A judge may feel that his desire for sexual relations is excessive or abnormal. He may react to his own unacceptable sexual feelings by handing out excessively severe sentences to those convicted of sexual offenses.	repressed reaction formation
58. We have studied a number of the commonly used defense mechanisms. There are others of course. Defense mechanisms may be used singly, or in combination with others and are used by all people, healthy or unhealthy. It can be seen that the methods used unconsciously to protect one's ego or self-image are many and varied. It is necessary for everyone to strive continuously to protect himself from feelings of anxiety and guilt. The methods and techniques which he employs in order to accomplish this are known as ego defense mechanisms.	No response necessary

When you have completed this programmed text, review all areas and the instructor will give you the final quiz over this area of instruction.

Department of Nursing
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STUDY GUIDE AND WORKBOOK 3ABR91431-2-I-6b
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MOTIVATION AND PERCEPTION

OBJECTIVES

Explain the general principles and relationship of motivation and perception to behavior.

INTRODUCTION

The behavior of any human being is, in almost all cases, learned behavior and is a reaction to stimuli, either internal or external. This study guide will help you understand this process and how it influences the lives of people.

INFORMATION

Motivation is defined as "the drive to meet the needs of the organism." This is almost self-explanatory. Each organism, and particularly the human organism, has needs which must be met. Humans are concerned with what others think of them and what they think of themselves. One can readily see the motivational forces which humans must contend with are of necessity, quite complex and complicated. These forces can be divided into two specific areas: Biological and Psychological.

Biological, or physiological, needs are the basic needs all humans share. The personality or individuality of the person does not alter this, although the method used in satisfying these needs may vary. Everyone occasionally becomes hungry or thirsty. There is a need to eliminate waste. Adults, as well as adolescents, have sexual urges or drives which in some way must be satisfied. Biological needs, then, are the needs which concern the physical well-being of the organism.

Psychological needs are much more complex. This is the area that governs much of our behavior. People become concerned about feeling secure in their role in life. They act in such a way that others will notice them and acknowledge their existence. The need to be wanted and loved is a basic psychological need noticed even in the smallest infant. This need is modified to some degree by the time adulthood arrives, yet it is still a driving force in our lives. The human also has a need to feel he has accomplished something with his life. Self-esteem not only makes us feel good but lack of it can result in feelings of dejection and ultimately suicide attempts. Psychological needs are the complex drives which influence our behavior on a social level -- the interaction between people depend on the motives of all the people involved. It can become a complicated process.

Motives are said to possess a hierarchy -- some must be met before others can be considered. First are the physiological or biological needs; hunger, thirst, sex, etc. Unless these needs are reasonably well gratified your behavior will be dominated by trying to fulfill them. When they are met, you can channel your energies to meeting other more complex needs. Second in the hierarchy of needs is safety or the avoidance of bodily harm or damage. If you feel safe in your environment, then you are able to focus on the giving and taking of love, which is third in the hierarchy. When you feel loved and wanted by others, you can consider your esteem (the 4th motive in the hierarchy). Your esteem is how you are thought of by others without the emotional attachment of love. If you have good self-esteem, then you concern yourself with the fulfillment of your goals in life or self-actualization. A diagram of the hierarchy of motivational forces is as follows:

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Self-actualization
↑
Esteem
↑
Love
↑
Safety
↑
Biological needs
(Hunger, thirst, sex)
↑
Person

Human behavior depends not only on your motives but also on how you perceive the world about you. Perception is defined as "receiving an impression through the senses to integrate and interpret past experiences in response to a present stimulus." All this means is that we react to any stimulus in a manner we learned will gratify us or meet our needs. We learned as children that heat (stimulus) will burn. We then react almost automatically by getting away from fire or quickly moving our fingers from a hot stove. Perceptual selectivity enables us to perceive aspects of the environment that is consistent with the motivational pattern operating at the moment. In other words, what is seen, heard and felt in a situation is influenced by what is happening to the person at the time as what has happened in the past. For example, a man dying of thirst on the desert has no eyes for the beauty of nature's handiwork. His motivational forces are basic -- get water to satisfy thirst. A pilot caught in bad weather has no thought for the beauty of flight, he is concerned with his safety.

With the background information you have just read, lets look at some of the applications as were seen in the film, "The Eye of the Beholder." As you recall, during the first half of the film we looked through the eyes of five different people and how each perceived Michael Gerard. Why did each person see what they saw and hear what they heard in thier dealings with Michael?

Of course, we cannot really answer that question. Since we were not present in the situations and we do not know what each person has experienced in the past, but we can speculate.

The waiter saw Michael as a "Lady's Man." The waiter says, "When I served him his first drink I could tell he was a lady's man alright." The waiter made this snap judgment from serving Michael his first drink. After that , the waiter saw and heard only those things which re-enforced his opinion. Why did the waiter make this snap judgment without knowing Michael? About the only clue we have to that answer is when the waiter say he recognizes a wolf when he sees one because "I know how to get around myself." In other words, the waiter who thinks of himself as a Cassanova is probably jealous of Michael's technique. These jealous feelings could direct his perceptions to re-enforce his strength.

The mother sees Michael as a "good boy, but thoughtless." She finds him very hard to understand and believes he never listens to a word she says (which, if you recall, is really a fault of hers). On this particular morning she had fixed Mike all his favorite dishes but he is so self-centered and unappreciative that he will not take time to eat the breakfast. She was so preoccupied with Michael eating his breakfast she did not hear his need to leave right away. Regardless of what the mother thinks, since Mike is her son he must be a "good boy" and she is able to overlook his misbehavior.

The Cabbie sees Michael as "a hood." Like the waiter, the Cabbie is an expert at rapid diagnosis of people -- "In my business you learn to size up a guy fast . . . right away. I had him spotted . . . he's a hood, a real hood." As the Cabbie talks to Michael, he complains of all the crookedness everywhere and then turns right around and asks Mike if he knew where he could get a good fix. This is a good example of the defense mechanism of projection or blaming others for your own shortcomings and mistakes. The Cabbie even projected in reality, that Mike had a revolver under his coat as the Cabbie did. The Cabbie is a frustrated hood who wants to belong and therefore perceives people through these eyes.

The Landlord sees Michael as "a looney." The first thing you hear from the Landlord is the fact that all artists are peculiar, which shows a good example of prejudice. Then, the Landlord projects his own craziness onto Michael after Mike told him some of his ideas about reality. When the Landlord was asked if he could recognize an insane person if he met one, he replied, "I'm an expert . . . . several members of my family are that way." As you can see it is fairly easy to understand where his ideas about people are coming from.

The cleaning woman sees Michael as "a murderer." This is a good example of a predisposition or making up your mind about something and then looking for evidence to support your position. Since this lady was fearful of everyone and their motives, she is watching for them to prove themselves, as he had to her. Since she wanted to find something bad about Michael she looked for enough evidence to fulfill this need.

We have looked at five different people's perceptions of one man. Each perception was influenced by their perceptual selectivity. Stop now, and think about your reactions to people. Are they honest or are they clouded by projections, predispositions, snap judgments, and prejudice.

Now, lets take what we have learned and apply it to the situations you will encounter as a PWS. You have seen perceptual problems that occur in the daily life of people. These will be magnified somewhat by the psychiatric patients you will encounter. The importance of communication to alleviate some of these misperceptions is of utmost magnitude and will be discussed during your hours on communication.

This process of perceptual selectivity is important in recognizing that the behavior of emotionally disturbed patients is dependent on how they perceive reality. Perception may become distorted when mental processes break down. The stimulus may be real or imaginary but the reaction is dependent on how they perceive this stimulus. The motives may seem peculiar to you but never the less are very real to them. They may see things you cannot see and will react to them according to the motivational pattern operating at that moment. A patient who is paranoid may hear a voice telling him you are going to kill him. He will react to this imaginary stimulus in much the same way you would if this were a real situation. He may hide from you or decide to get you first. Your role as a Psychiatric Ward Specialist is to recognize this pattern, point out the reality of the situation and avoid any emotional involvement which may result.

Remember motives drive us -- perception determines how we see reality and a combination of the two determine our behavior. This means that all behavior is purposeful. Since each person perceives reality differently, behavior to any stimulus will vary. Each person continues to learn ways of meeting needs; therefore, individuals differ and have the capacity for changing their behavior.

Questions

Answer the following questions by filling in the correct answer.

1. The drive to meet the needs of an organism is called ____________________.

2. Motivational forces can be divided into two specific areas:

a. ____________________

b. ____________________

3. The hierarchy of motives are as follows:

e. ____________________

↑

d. ____________________

↑

c. ____________________

↑

b. ____________________

↑

a. ____________________

↗

PERSON

4. ____________________ is defined as receiving an impression through the senses to integrate and interpret past experiences in response to a present stimulus.

5. ____________________ enables us to perceive aspects of the environment that is consistent with the motivational pattern operating at the moment.

6. Motives drive us -- perception determines how we see reality and the combination of the two determine our ____________________.

7. All behavior is ____________________.

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

PREDISPOSING AND PRECIPITATING FACTORS

April 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

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Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

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PREDISPOSING AND PRECIPITATING FACTORS

OBJECTIVES

State the principles of predisposing and precipitating factors in mental health.

INTRODUCTION

In previous lessons we have discussed personality development and what happens when stress becomes too great. Both of these have paved the way for an examination of the causes of abnormal behavior -- faulty development and excessive stress.

In studying the causes of abnormal behavior, it is helpful to divide the factors into three categories; biological, psychological and sociological. These factors interact with each other in varying degrees to produce the mental disorder. For example, syphilis of the brain may have been contracted by the contribution of sociological factors along with psychological factors affecting the degree of personality breakdown; both contributing to the abnormal behavior of the person afflicted.

Causative factors are also divided into predisposing and precipitating causes. Predisposing factors go before and pave the way for later psychopathology by lowering the individual's adjustive ability. For example, the child who is rejected in childhood may have adult adjustment problems if the situation arises. Precipitating causes represent the particular condition such as loss of a loved one or a brain disease, which proves to be too much for the individual and precipitates the symptoms. It should be noted that the exact pattern of predisposing and precipitating causes for abnormal behavior may be far from clear. What may be a causative factor forone, may in turn stimulate the other and both work on producing symptoms of abnormal behavior.

INFORMATION

Now let's take a look at each of the predisposing and precipitating causes separately. With each one we will look at the biological and psychological factors involved.

The following outline is presented to help you visualize the organization of this study guide.

CAUSES OF MENTAL ILLNESS

1. Predisposing causes

    a. Faulty biological development

        (1) Heredity

        (2) Constitution

        (3) Congenital and acquired defects

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- b. Faulty psychological development
  - (1) Early deprivation
  - (2) Unhealthy family patterns
    - (a) Rejection
    - (b) Overprotection
    - (c) Overindulgence
    - (d) Perfectionistic demands
    - (e) Unrealistic moral standards
    - (f) Faulty discipline
    - (g) Sibling rivalry
    - (h) Marital discord and broken homes
  - (3) Early psychic traumas
  - (4) Inadequate preparation for adolescence
  - (5) Lack of competencies for adulthood
- c. Faulty sociological development

2. Precipitating causes
   - a. Severe biological stress
     - (1) Fatigue and dietary deficiencies
     - (2) Accidents and disease
     - (3) Toxic and organic brain pathology
     - (4) Disruptive emotional processes
   - b. Severe psychological stress
     - (1) Frustrations
       - (a) Failure
       - (b) Losses
       - (c) Envious status comparisons
       - (d) Personal limitations
       - (e) Guilt
       - (f) Unrelatedness and lack of meaning

- (2) Conflicts
  - (a) Avoiding vs. facing reality
  - (b) Dependence vs. independence
  - (c) Fear vs. positive action
  - (d) Love vs. hate
  - (e) Sexual desires vs. restraints
- (3) Pressures

c. Severe sociological stress

- (1) War and threat of war
- (2) Occupational problems and economic changes
- (3) Marital unhappiness and family instability
- (4) Racial discrimination
- (5) Rapid social change

PREDISPOSING CAUSES

Faulty Biological Development

This may be a predisposing factor for abnormal behavior. Since our behavior is based upon the quality and functional completeness of our nervous system and other body equipment, any factor which can interfere with normal physical development must be considered as a potential cause of abnormal behavior. Either heredity or environmental factors may be responsible for such interference in normal development.

HEREDITY. A type of biological factor that can predispose abnormal behavior. Due to the fact that a person is a product of his biological inheritance, it is likely that genetic factors do play some role in psychopathology. The type of hereditary factors that may predispose abnormal behavior are chromosomal aberrations and mutant genes. In the former, studies have shown that abnormalities in the number or structure of the chromosome are associated with a wide range of birth malformations and hereditary diseases. For example, mongoloid children are found to have an extra chromosome. Chromosome irregularities usually result in defective body structure rather than in mental disorders. In the latter, the emphasis is placed on the losses, gains, or changes in the gene itself. Mutant genes, like the chromosomes aberrations, have been found primarily with specific structural defects rather than a neurosis or functional psychosis. Examples of mutant or defective gene disorders are Huntington's Chorea and phenylketonuria (PKU).

CONSTITUTION. The constitution of a person may also be a predisposing biological cause for abnormal behavior. By constitution, we are referring to both the innate and acquired assets and liabilities of a person. Such things as sex, temperament, blood type, and physique are examples of a person's constitution. Many studies have been completed on aspects of a person's constitution as related to their personality. For example, W. H. Sheldon concluded there are three body types and three complementary temperaments for each type.

CONGENITAL AND ACQUIRED DEFECTS. The last type of the biological predisposing causes. We are referring here to deformities and imperfections of our bodies, such as lameness, deafness, and blindness. There are approximately twenty million people in the United States with chronic diseases or physical imperfections that limit their activity. Naturally, these people have a difficult situation to adjust to. Feelings of inferiority, self-pity, fear and hostility are common reactions. Even people with slight physical defects such as crooked teeth, skin blemishes, tallness, shortness and glasses may find this traumatic and hard to adjust to.

Faulty Psychological Development

Now let's look at another type of predisposing factor for abnormal behavior; faulty psychological development. As you recall from your lesson on personality development, the early years (birth to 6) are the period in which foundations are laid for adult environmental evaluations and self-evaluations, habits of thinking, and patterns of reaction. However, as we mature we are capable of critical reflection and evaluation that may change our patterns of thinking and action. Faulty psychological development involves:

- Immaturities or fixations in which the person fails to develop one or more of the dimensions of maturity.

- "Weak spots" as when traumatic experiences leave him sensitized and vulnerable to certain types of stress.

- Distortion, as when he develops inappropriate attitudes or reaction patterns or fails to achieve.

Unhealthy Psychological Development

EARLY DEPRIVATION. Can do much damage to the developing individual. Infants [illegible] of adequate maternal care due to either separation from the mother and placement in an institution or lack of adequate mothering in the home, suffer from maternal deprivation. One can easily comprehend the fact that an infant raised in an institution is less likely to have received a mother contact plus less intellectual, less emotional, and less social stimulation, and a lack of encouragement and help in learning. The extent and quantity of the damage vary with the age at which deprivation occurs, with the length of time it persists, and with the quality of substitute care provided. In a study done by D. Beres and S. J. Obers of 38 adolescents who had been institutionalized between the age of three weeks and three years of age: 4 were diagnosed as psychotic, 21 as having a character disorder, 4 as mentally retarded and 2 as neurotic, 16 to 18 years later. Only 7 were perceived as having a satisfactory personality adjustment. But, the greatest number of infants suffering from maternal deprivation are not separated from the mother, instead they receive inadequate maternal care. Mothers that reject, punish, or are indifferent to the infant, can cause negativistic behavior on the part of the infant even at a very early age. General environmental deprivation also affects the infant's development. Deprivation of any needed elements or condition in his early life may have lasting adverse effects.

UNHEALTHY FAMILY PATTERNS. More unhealthy psychological factors are found in the different types of unhealthy family patterns. As a child progresses from infancy into childhood, the family remains the main guiding influence in the child's personality development. Faulty parent-child relations or unhealthy family interactions are a definite source of maladjustment. Whether parents do too much, too little or teach the child inappropriate reaction patterns, their methods tend to be fairly consistent during the child's growing years. Let's now look at some faulty parent-child relations and see the possible effects on the child.

Rejection. Rejection of a child by the parents may have serious and lasting effects upon the child's personality. It is important for a child to feel loved, wanted, and accepted by his parents, for they are his main source of security. If his parents do not see him as being of worth or significance, it is difficult for the child to think of himself in a positive way. Since the child is never rewarded he cannot discriminate between approved behavior and disapproved behavior. Rejected children tend to be fearful, insecure, attention-seeking, jealous, hostile, aggressive and lonely.

Overprotection. Smothering of a child;s growth is termed overprotection. The mother watches over the child constantly, preventing him from all contact with outsiders and from letting the child make his own decisions. In protecting the child from all dangers, the parent denies the child opportunities for needed reality testing and for developing needed competencies. These overprotected children often tend to be passive and feel helpless in the face of a dangerous world.

Overindulgence. Overindulgence, where one or both parents cater to the child's slightest desires, is another type of pathological family pattern. These children are characterized as being very spoiled, selfish, and demanding. Whereas the rejected child finds it hard to enter into a warm human relationship, the overindulged child has no problems. He then exploits the relationship for his own purposes, like he did his parents. These children usually rebel against authority and are very impatient. They have an agressive, demanding attitude.

Perfectionistic Demands. Perfectionistic demands upon a child, can be a big source of frustration for the child. No matter how hard the child tries, he somehow seems to fail in the eyes of his parents. They may push him to obtain the highest grades or be the best athlete, whether it is in his capacity or not. Soon the child not only seems to fail through the eyes of his parents, but also through his own eyes, which undermine the child's sense of adequacy and worth and may discourage further effort on his part.

Rigid Moral Standards. Rigid, unrealistic moral standards that parents impose upon a child, can also do their damage. The internalization of extremely rigid parental values leads the child to be critical and severe in evaluating his own behavior. Sometimes the child rebels against severe moral restriction and goes to the other extreme. For instance, the girl whose parents have extremely rigid moral standards, may rebel and end up facing delinquent sexual behavior charges. Whatever the moral standards are, from sex to card playing, the parents force the child to face many guilt-arousing and self-devaluating conflicts.

Faulty Discipline. Faulty discipline upon the part of the parents is another type of unhealthy family pattern. This faulty discipline may be the result of a misinterpretation by the parents of some theory stating that a child must not be frustrated or disciplined in any way. This of course produces an overly permissive home and a spoiled, inconsiderate and insecure child. Overly severe discipline is another type of faulty discipline resulting in fear and hatred of the punishing person. A child who is severely beaten often by his father, naturally learns to fear and hate the man. Inconsistent discipline, another form of faulty discipline, makes it difficult for a child to establish stable values for guiding his behavior. One time he is punished, one time he is ignored or rewarded, so naturally the child is confused as to what is appropriate. A child needs to know what behavior is expected of him, so that he can develop healthy inner concepts and value controls.

Sibling Rivalry. Sibling Rivalry is a frequent type of faulty parent-child relationship. Sibling jealousy and rivalry for parental affection may lead to marked feelings of insecurity. These feelings can be dealt with and disappear if the parents make each child feel he is important and precious to them.

Marital Discord and Broken Homes. The last type of faulty parent-child relationship we are going to study is the effects of marital discord and broken homes. Parents who cannot get along represent a threat to a child and he responds by developing tension himself. Often the child receives some displaced tensions from the parents. Broken homes also lead to feelings of insecurity. A child may have to learn to split his love or may lack a parental model to help him pattern his behavior.

EARLY PSYCHIC TRAUMAS. We have studied the effects of early deprivation upon the child and also the effects of unhealthy family patterns. Now let's look at another unhealthy psychological development factor--the effects of early psychic traumas. No matter what the age of a person, a psychic trauma may adversely affect the development and adjustive behavior of a person. In general, early traumas seem to have more far reaching consequences in the young, due to the fact that their self-defenses are not yet as prominent to handle the trauma. Some traumas, such as losing a parent, or finding out one is adopted, are apt to leave psychological wounds that never completely heal.

INADEQUATE PREPARATION FOR ADOLESCENCE. This falls in line with the other faulty psychological developmental factors. During adolescence a person is faced with many changes not only physical but social as well. During this period, he must establish himself as a person apart from his family and work out situations such as his future occupation, education and marriage. The adolescent is uncertain about who he is and what life is all about, and is searching for these definitions. If a person has not had adequate preparation in childhood for this complex period, then he will have trouble resolving his conflicts.

LACK OF COMPETENCIES FOR ADULTHOOD. This can also be an important factor in the causes of mental illness. During adolescence and early adulthood, the individual is acquiring various competencies important for adult living--such as earning a living, parenthood, and getting along with other people. If one has an inadequate physical, social, emotional or intellectual development, then this will naturally affect his adulthood adjustment to varying degrees. For example, a person who feels ill at ease in a group may withdraw from social participation as much as possible, or even compensate with an exaggerated independence in which he belittles the group as stupid and confining. This would be an inadequate social competency.

Sociological Factors in Faulty Development

We have studied the biological and psychological aspects of predisposing causes of abnormal behavior. Now let's look at the predisposing sociological factors in faulty development.

The influence of sociological factors upon a person is a double one. First, they play a large part in shaping the kinds of attitudes and stress reactions a person develops, and secondly, they initiate the kinds of stress a person must face. The functioning of every part of the human body is moulded by the culture in which the person has been reared, This includes occupational hazards, his exposure to disease, his diet, traumatic experiences, catastrophes, and the way his particular culture disciplines, feeds, fondles and rewards their children. A family in Africa will raise their offspring in many different ways than a family in Iowa. One can readily see how influential a society (culture) can be on the development of a personality.

Now let's turn our attention from the predisposing causes for abnormal behavior to the precipitating causes. Again, we are going to look at the biological, psychological and sociological factors precipitating the behavior.

PRECIPITATING CAUSES

Biological Stress

Severe biological stress may serve as a precipitating factor to abnormal behavior. Some examples of biological stresses are as follows:

FATIGUE AND DIETARY DEFICIENCIES. A person must constantly revitalize himself through rest and through taking various nutrients to replace the ones that have been used up. If a person does not have rest or food for prolonged periods, it makes him highly vulnerable to special stresses. For example, prisoners of war have displayed highly abnormal behavior simply because of lack of food and sleep.

ACCIDENT AND DISEASE. Accidents to a person or his loved one, may prove highly stressful. If a person is killed or permanently injured, this presents stress to either the person or the loved one. Chronic disease, like heart conditions, also place a person in a stress situation. To them, life itself poses a continual threat. A person who had a cancer operation, lives with the fear that all the cancer cells within them were not killed and will again become active.

TOXIC AND ORGANIC BRAIN PATHOLOGY. Approximately one half of all patients in mental hospitals are suffering from disorders associated with toxic or organic brain pathology. This means either destruction of brain tissue or interference with normal brain functioning. The brain damage and also the personality organization of the individual plays important parts in the associated abnormal behavior. Some people become severely disordered with only slight brain damage, whereas a more stable person is able to compensate successfully for much more damage.

DISRUPTIVE EMOTIONAL PROCESSES. Emotional processes like fear and anger represent the mobilization of body resources to meet the threat. When this happens, a person has a great need to eliminate the fear and anger even though his actions may be socially inappropriate. As the level of emotional tension increases, it becomes increasingly disruptive to organized behavior. For example, extreme fear may lead a person to a panic reaction during a fire and he may stand paralyzed by fright.

Psychological Stress

Now that we have looked at the biological precipitating factors to abnormal behavior, let's concentrate on the psychological stresses that lead to abnormal behavior. Naturally, there are many kinds of frustrations, conflicts and pressures a person is confronted with a and must deal with, but we are just going to look at a few of the stresses and the consequences.

FRUSTRATIONS LEADING TO SELF-DEVALUATIONS. You recall from previous lessons, that the feelings of adequacy and worth are basic needs, and that we develop a system of defense mechanisms to protect these needs and prevent self-devaluation. A person must think he is a fairly good person and feel adequate to deal with problems if he is to maintain a psychological balance. Some of the common frustrations that lead to self-devaluation and are hard to cope with are as follows:

Failure. In our highly competitive society, where goals are high and success is prominent, sometimes a person can not make what he sets out to do. His goal may be too high or he may get beaten out of a job by a rival, resulting in a feeling that he has failed. Failure leads to strong feelings of inferiority and self-devaluation. If these failures are not accepted, understood and used constructively to learn by, then permanent feelings of inferiority and fearfulness set in.

Losses. Losses of objects we treasure or losses of persons whom we love and identify with may be sources of frustration. If a person loses all his money or his social status, then this may lead to severe self-retaliation and self-devaluation in his eyes as well as society. Or if the loss is a loved one, this is a traumatic experience and requires time for adjustment.

Envious Status Comparisons. Few people ever attain the status in society that they would like to achieve. People fantasize about being a wealthy movie star, or a professional athlete, or marrying a beautiful and exciting wife. But, when our fantasies lead us to the tendency to compare our achievements and status continually with others, it may become a source of frustration and self-devaluation.

Personal Limitations. Personal characteristics which are admired by a group are assets in raising feelings of adequacy and self-esteem; whereas, characteristics which the group ignores or disapproves of, are likely to lead to self-devaluation. We are continually comparing ourselves with others and usually do not receive much satisfaction.

Guilt. Guilt is one of the chief sources of self-devaluation. Many times our behavior leads a person to feelings of guilt and self-devaluation, which is extremely frustrating. We have been taught that when one does something wrong, this leads to punishment. Thus, when we behave in ways which we view as immoral or hostile, we experience self-devaluation and apprehension.

Unrelatedness and Lack of Meaning. Feelings of isolation and loneliness are another potent source of self-devaluation and discouragement. Some people believe they are alone in this world, others do not understand or care about them. One can readily see how adversely this would affect the person. Some people also believe there is no meaning in life. To them life is wasted, futile, empty and there is no use to care or even hope. Thus the person lives out of despair.

Conflicts

AVOIDING vs. FACING REALITY. Reality is often an unpleasant and anxiety arousing factor that a person either faces squarely or by the use of a defense, avoids. We all tend to see what we want to see, hear what we want to hear and think what we want to think. Therefore, if we see something or hear something or think something we do not want, we may try to avoid it by the use of a defense against it. To avoid reality is much easier than to face it.

DEPENDENCE vs. INDEPENDENCE. All of us have to make the transition from the dependent child to adulthood and responsibility. This is a very difficult transition and when the going gets tough, one may wish to regress back to the somewhat dependent position by marrying a person who will care for them as their parents did. Others, not successfully confronting this conflict, may become lifelong inmates of a mental hospital where they are cared for and very dependent.

FEAR vs. POSITIVE ACTION. Fears resulting from the dangers of life are often overreacted. Most of us realize that the more fear we feel, the more tension that builds up and the greater the desire to escape the fear. But also, along with feeling fear comes fatigue, worry, sensitivity to criticism, indecision and egocentricity. Many people try hard to fight the feeling of fear by denying or concealing it, instead of learning to function in spite of it.

LOVE vs. HATE. Ambivalence complicates most of our relationships with loved ones. To love a person and yet to discharge the hostility involved with that person, so as not to lose the person, is a hard process to master. This is especially seen in the parent-child relationship. Love may also result in being a risk for a person. He may love someone who does not love him in return, or he may lose a loved one through death. Therefore, love may result in being hurt or frustrated and cause a person to avoid emotional involvement at the risk of being hurt. But, despite the dangers involved, most people strive to establish warm relationships with others.

SEXUAL DESIRES vs. RESTRAINTS. Due to the social taboos placed on the expression of the sex drive, many conflicts arise to the individual. These conflicts are found in childhood with the idea of masturbation and the Oedipal complex; in young adulthood where questions of petting, premarital sex relations and infidelity after marriage are aroused; and through adulthood and parenthood when one starts raising his own offspring.

Pressures

Not only are there frustrations and conflicts that cause severe psychological stress, but also pressures. Pressures may stem from inner or outer sources. In some cases, we learn to live with them, but in other instances they are uncomfortable and may lead to a breakdown of organized behavior. In our society we compete for most things we desire. We compete for jobs, status, marital partners and most everything else. We drive ourselves to obtain achievements and in doing so we undergo severe pressure to succeed. Of course, if we do not succeed there are emotions involved we must adjust to. There are many pressures on a person such as educational, occupational, and marital which one has to work with and live with his entire life.

Sociological Stress

Severe sociological stress is the last precipitating factor we are going to look into. Some of the common sociological stresses are as follows:

WAR AND THREAT OF WAR. This is a type of sociological stress that is very prevalent in society today. Most mankind lives in fear of the new and incredibly destructive instruments of modern warfare.

OCCUPATIONAL PROBLEMS AND ECONOMIC CHANCES. This constitutes another fear in any man desiring to achieve. If a man is unhappy in his job, or has to retire when he is not ready, or cannot find a job, or feels inadequate in his job, then his behavior will also be affected. Realizing from previous reading and the importance of success, and of obtaining goals and status, one can readily see the importance of a person's work and his satisfaction with his work.

MARITAL UNHAPPINESS AND FAMILY INSTABILITY. If a marriage ends in divorce or if a couple just live together with deep dissatisfaction, there are emotional elements involved that have to be dealt with by each party. The role of the family is in part to meet the needs of the individual and to give satisfaction not only through childhood but throughout the life span of an individual. It has been estimated that one half of all the married couples, would not pick the same mate if they had to do it over again. Now, imagine some of the individual emotions involved in the above approximation. Many people are unhappy in marriage or with their family situation, which means they must make an adjustment to this.

RACIAL DISCRIMINATION. This seems to be a prevalent social stress in society today. People everywhere are rebelling against discrimination. Today the idea of equality is widespread; people want to be treated and respected as human beings. Of course, the adjustment is not difficult for the people in the accepted or majority position. But, the person in the outside group has many emotions to deal with because of racial discrimination. The resulting effects upon personality development are widespread both individually and socially.

RAPID SOCIAL CHANGE. Rapid social change can create serious problems for man. Traditional morals, values, and many assumptions concerning the meaning of human existence are subject to revisions due to social change. Due to social change for example, many people's ideas about sex and the expression of sexual entities are freer and more liberal. As the result of social change, many people are groping about, bewildered and bitter, unable to find any enduring faith or philosophy of life.

Summary

In summation, man's adjustment depends on the level and types of stress in relation to the person's personality development. Keep in mind the predisposing and precipitating factors, whether of a biological, sociological or psychological nature, may reinforce each other, counterbalance each other and always play a part in our behavior.

Questions

1. What is a predisposing factor? What is a precipitating factor?

2. Give three predisposing psychological causes for abnormal behavior.

3. What is meant by the constitution of a person?

4. One of the faulty parent-child relationships discussed was rejection. Explain the possible effects of rejection on a child.

5. What does it mean to overindulge a child? What effect does this have on the child?

6. What are the three types of precipitating psychological factors that may lead to abnormal behavior?

7. Give an example of a conflict that may be stress producing and explain the conflict.

8. What effect does racial discrimination have upon an individual?

9. What is meant by the downward spiral? Answer from notes in class.

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DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

PRINCIPLES OF MENTAL HEALTH NURSING

April 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

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Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

PT 3ALR91431-I-
April 1975

PRINCIPLES OF MENTAL HEALTH NURSING

OBJECTIVE

Explain the principles of mental health nursing as it affects patients, family, and staff.

INTRODUCTION

As you work with patients you will become comfortable enough in your relationship with them only when you feel some security about your ability to respond appropriately to the patient's behavior.

This programmed text is a presentation designed to familiarize you with principles or guidelines of mental health nursing that will help you to respond appropriately to the patient's behavior.

INSTRUCTIONS

This text is designed so that you will go through it step by step. Each frame or step of instruction is designed to teach you a small bit of information. Confirmation of each step is given immediately below the slashes (////). You should slide a mark (piece of paper) down the page until the slashes are barely exposed. Read the information and respond as directed. Then, slide the mark downward and confirm your response. Do not proceed until you have responded correctly. If you make any errors, review the written material before continuing.

This supersedes PT 3ALR91431-I-9, November 1974

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INFORMATION

In your previous classes you have been introduced to knowledge that has given you a basic foundation in the mental health career field. This foundation is to prepare you for the work you will be doing; specifically, communicating with and interacting with patients. As you begin working with people who are mentally ill, it is well for you, the specialist, to keep in mind that the behavior of these patients can cause much anxiety. There is always the feeling that you may say the wrong thing or that you may not be able to properly handle a situation. Faced with these situations, you may let your response to patients be determined by the need to protect yourself from the anxiety aroused. For example, if a patient becomes hostile towards you, you, in order to protect your self-esteem, may return hostility to the patient. You might say to yourself, "Who does he think he is - talking to me in that manner. I'll show him." As you become skilled in your relations with patients you will in most instances be aware of these feelings. It is important for you to realize that it is perfectly natural to feel anger, resentment, pity, and dislike as well as liking for patients. You cannot turn your feelings on and off. You will find, however, as you become skillful in your relations with patients that whatever feelings or emotion you may have toward a patient will be kept under control.

Upon entering the mental health career field new personnel:

a. Are confident.

b. Are anxious.

c. Have no feelings one way or the other about their new experience.

d. Feel that their thoughts and feelings about the new experience is abnormal.

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b

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Although no one can ever completely "know himself" it is possible for people to look more closely at themselves and their relationships with others. It is not an easy task, but in the long run it becomes a highly rewarding experience. Through increased understanding of one's own behavior, one is better able to understand the behavior of others.

You can begin to understand yourself by:

1. Learning as much about human behavior as you can; this increases your understanding of what is actually happening.
2. Accepting yourself as part of learning how to accept others.
3. Making a conscious effort to be aware of your own behavior, feelings, and responses to various problems and situations. For example, in your relationships with patients you might ask yourself these general questions:
    a. How do patients respond to me?
    b. What are my feelings about mental patients?
    c. What kind of judgments do I make about patients?
    d. How do I react to these feelings and judgments?
    e. Why do I particularly like or dislike certain patients?
4. Talking over such questions with a co-worker, instructor, or supervisor will sometimes bring to light valuable information which we might not be able to perceive in ourselves.

In beginning to understand yourself, you will have made an important step in attempting to understand others.

The task of "knowing myself" as part of learning how to accept others is:

a. easy

b. difficult

c. impossible

d. not necessary

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b

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Since we all come from a variety of backgrounds, possess different personalities and different likes and dislikes we all perceive and react to another's behavior in different ways. What you bring to a therapeutic relationship is your own unique contribution; what you are as a person, which is different from what any other person is. This is one of the reasons why there are no standard replies to patient questions, no standard pattern of behavior for any situation in a psychiatric setting. The same word used by two different specialists may have two different meanings to the same patient. However, regardless of the pattern of behavior that may characterize a patient's behavior disorders, there are certain general principles that apply to the care of all who show such disorders. The first guideline or principle that will be discussed is:

ACCEPTANCE - You know by now what acceptance means. It means acknowledging by your attitude that the patient has a right to behave as he does. It does not mean that we sanction or approve his behavior nor does it mean that the specialist must lose control of the situation.

Acceptance is a series of positive behaviors designed to convey to the patient a respect for him as an individual human being who possesses worth and dignity as such.

Acceptance of the patient means that you:

a. Sanction his behavior.

b. Disapprove of his behavior.

c. Lose control of the patient.

d. Acknowledge that the patient has a right to behave as he does.

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d

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Acceptance is expressed through many avenues of approach:

1. Non-judgmental - This means that we avoid all moral judgment and its expression. For example, it is not wrong to feel somewhat shocked when a patient is crude or vulger but it is wrong to make a patient feel he has offended you and needs to be punished.

When you accept a person as he is without reproach and without passing moral judgment, you are being:

a. Condescending

b. Non-punitive

c. Non-judgmental

d. Forgiving

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c

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2. Non-punitive - A non-punitive approach to patients means that although they are encouraged to express their feeling and although their behavior may not meet social standards, patients are punished neither directly nor indirectly for their expressions or behavior. You are probably thinking that you would never punish a patient. However, there are ways, other than physical, of punishing people. You may yourself actually have been the recipient of some of the following punitive measures.

a. Avoidance - avoiding contact with a patient except when something must be done for him.

b. Tell him something unpleasant for his own good.

c. Call attention to his defects by talking about them.

d. Fail to explain what is being done to him.

e. Maintaining a superior attitude.

A non-punitive approach to patients is one in which the patients are:

a. Not punished directly or indirectly for their behavior.

b. Punished because they deserve it.

c. Allowed to punish others.

d. Judged to be either good or bad.

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a

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3. Another method of accepting patients is to show interest in the patient as a person. Interest in the patient as a person must be shown in the presence of the patient, or where the patient can see evidence of such interest in order for it to have any effect on his feelings of behavior. Interest can be shown in many ways. Think of how you hehave toward someone in whom you are interested and you will have a better understanding of how to show you are interested in patients.

First of all, when you are interested in someone you want to spend as much time with them as you can. You may call them or you may make some attempt to see them. You, in essence, seek the person out. In addition, you become aware of the other persons's likes and dislikes so that when you are together, you are doing something that he or she is interested in. Since your aim is to please this individual, you try to meet their requests knowing that if you can't you will explain to him/her the reason you can't. For example, if your boyfriend/girlfriend wants to spend a night out on the town and it is two days before payday, you may not be able to meet this request even though you want to.

Staying with a person, which seems relatively simple, also conveys acceptance. This all becomes more meaningful to you when you recall the times you quietly sat with a friend or relative or vice versa.

We don't show interest in the patient as a person in his presence because it would retard his recovery.

TRUE or FALSE (Circle One)

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False: Interest in the patient as a person must be shown in the presence of the patient, or where the patient can see evidence of such interest in order for it to have any effect on his feelings or behavior.

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4. Acceptance can be conveyed to patients by recognizing the feelings they do express. Anger as a response to an emotional need is also fairly common among mental patients. Anger usually follows frustration. That is, a person wants something, or wants to do something, and, at every turn, is stopped. After so long a time something has to give, and usually it is a person's patience. Anger can be vented by verbal or physical abuse toward someone or something outside of one's self. There is less control present when a patient responds angrily to a felt need. He may shout, cry, threaten or be destructive.

As long as no harm is done to other persons or things, it is helpful to allow such expressions of anger, because in this way he "blows off steam." When the outburst is over, the patient can be dealt with much more practically than if the outburst were interfered with. "Blowing off steam" affords the patient an opportunity he may never have had -- ventilation or expression of his feelings. If you can learn to accept, non-judgmentally and non-punitively, the expressions of emotions and feelings and then learn to accept one's self as a realistic sounding board for the patient you will have taken the first step in helping the patient toward recovery.

As long as no harm is done to other persons, a patient should be allowed to expose negative emotions without fear of retaliation or reproach by the staff.

TRUE or FALSE (Circle One)

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TRUE: Expressing emotions or "blowing off steam" affords the patient an opportunity he may never have had; ventilation of the feelings.

///

5. The last method of conveying acceptance that we shall discuss is that of listening. Listening is an art. It means more than keeping quiet -- encouraging patients to do the talking through brief, non-directive comment and through interest in what the patient is saying can be a rewarding experience. Effective listening requires a concentration on the person talking and not a concentration of how the listener will respond.

Match the following types of approaches with their definitions:

Approaches that convey acceptance	Definition
_____ a. Listening	1. Avoid all moral judgment and its expression.
_____ b. Non-punitive	2. No punishment of patients
_____ c. Showing interest	3. Ventilation
_____ d. Non-judgmental	4. Concentration on the person talking
_____ e. Let patient express his emotions.	5. Seek the patient out.

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a-4; b-2; c-5; d-1; e-3

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The second guideline that will be discussed is that of Seeking Validation from the Patient. Another term for this is checking it out. Only the patient can know how each experience looks to him. You know from your class on motivation and perception that people react to or in a situation the way they see it and the way they see a situation depends on their past experience and their feelings at the moment.

For example, you notice that your friend who is usually friendly and cheerful has suddenly begun to ignore you. If you do not find out why your friend is behaving this way you may think that he is angry with you and you may then react in anger to your friend. To prevent misinterpreting your friend's behavior you will so state and check with him whether your feelings about his behavior are right or wrong. And this is what seeking validation means.

Specialist: "You seem to be avoiding me."

Friend: "No, it's not you personally. I just don't feel well today."

Specialist: "Would you like to talk about it?"

The basis of the helping relationship is the ability to convey to the person the sense of trying to understand him and his feelings, as they appear to him. Seeking validation or checking this out convey this effort.

You are sitting in class and you notice that two other students are looking at you and laughing. You become uncomfortable because you feel the students are either talking about you, or are making fun of you. Your first reaction is one of anger at these students; however, you decide as you think about the situation that you are not really certain that they are laughing at you. So you wait until break time when you can ask the students about their behavior. This is an example of:

a. Postponing gratification

b. Setting limits

c. Reality principle

d. Seeking validation (Checking out)

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d

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CONSISTENCY AND PATIENT SECURITY - All mentally ill patients are insecure and uncertain, no matter what their behavior may appear to be on the surface. Therefore, attention to the small and large details that contribute to security is necessary. Not knowing what to expect produces anxiety. Consistency, or uniformity, in all areas of activities and experience is valuable to the psychiatric patient for it builds in his environment somethink upon which he can depend.

The use of consistency is of value in routine, in attitude and in defining the limitations placed upon the patient. A fairly consistent routine in a psychiatric hospital helps the patient by reducing the number of decisions he is called upon to make and by giving him something upon which to rely.

Consistency in the attitude of personnel toward him is profoundly important to the psychiatric patient. It helps him if he learns through day-by-day contact exactly what he can expect as long as it is possible. It is even more helpful if he is constantly and continuously exposed to an atmosphere of quick acceptance. Consistency in attitude on the part of the individual members of personnel is important, but consistency from person to person and shift to shift should be deliberately planned. The necessity for teamwork is quite obvious.

Consistency in all areas of activities and experience is valuable to the psychiatric patient because it

a. Prolongs his hospitalization

b. Makes him dependent on the staff

c. Builds something upon which he can depend

d. Increases patient's preoccupation with small and large details

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c

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Although we are accepting of a patient's behavior and we allow a permissive atmosphere, the permissiveness is limited. Patients cannot be allowed to do exactly as they please for obvious reasons. The homicidal patient is not permitted to kill others; the suicidal patient is not permitted to kill himself; the overactive patient is not permitted to completely exhaust himself, nor is the suspicious patient permitted to starve himself.

A permissive atmosphere on a mental health unit means that patients are allowed to do exactly as they please.

TRUE or FALSE (Circle one)

//

FALSE - Although we allow a permissive atmosphere patients cannot do what they please for obvious reasons.

//

That the patient feels and has a right to feel that way is accepted, but limitations are drawn beyond which his behavior is not allowed to go. The "setting of limits" and their enforcement are tasks that require a great deal of tact and understanding, since the potential psychological threat to the patient may be handled in such a way as to place the patient on the defensive in his relationships with personnel. Consistency in quiet, matter-of-fact enforcement of limitations is one of the most effective methods of using the limits as a contribution to the patient's security.

Drawing limits on a patient beyond which his behavior is not allowed to go is known as:

a. Setting limits

b. Being authoritarian

c. Being punitive

d. Being permissive

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a

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The attempt to win a patient's liking by being more permissive with him than other members of personnel is disastrous for the patient. This only contributes to the patient's confusion and insecurity. Actual limitations on a patient's behavior should be determined by the team under the direction of the physician, and those limitations should be consistently enforced by everyone who comes in contact with the patient.

Limitations on a patient's behavior are determined by the:

a. Nurse

b. Doctor

c. Technician

d. Team

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d

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The fourth guideline, letting the patient set his own pace, may be a little difficult for you to understand at this time, but it will have more meaning for you as you begin working with patients. By letting a patient set his own pace means that you do not attempt to reason him out of his emotional difficulty. A problem for most personnel who work with mentally ill patients is the belief that a change in behavior is easily produced by the use of reason. If we tell a patient what he ought to do and why he ought to do it, we expect him to change his way because "he knows better." When a patient doesn't change then we are disappointed. It is well to remember that if a patient could be reasoned out of his psychotic ideas, he would never need treatment in a hospital.

Additionally, new workers in the mental health field have a tendency to believe that since they are interested in patients and since they spend a lot of time interacting with patients, the patient should get well in a hurry. Putting a time limit on a patient's recovery only serves to frustrate personnel and the patient when personnel's expectation of them are not realized. Give the patient time to get well; he didn't become ill overnight.

Letting a patient set his own pace means that you let him (the patient) do as he pleases.

TRUE or FALSE (Circle one)

//

FALSE - Letting a patient set his own pace means that you do not attempt to reason him out of his emotional difficulty.

//

Avoid increasing the patient's anxiety is the fifth guideline.

Fear and anxiety are already problems with which the patient is unable to cope. Subjecting the patient to additional anxiety only serves to retard his recovery. There are certain types of situations which can be avoided since an increase in anxiety can almost safely be predicted if the situation arises.

1. Do not contradict the patient's psychotic ideas.

You will only succeed in further upsetting the patient. For example, a patient who believes he is Jesus Christ Superstar will not stop believing he is Jesus Christ just because you tell him he is not who he thinks he is.

Contradicting the patient's psychotic ideas:

a. Hastens the patient's recovery.

b. Only serves to increase the patient's anxiety.

c. Is necessary because the patient has to know he's not thinking properly.

d. Lets the patient know that the specialist is smarter than he.

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b

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2. Demands upon the patient that he obviously cannot meet are also anxiety producing. To insist that a depressed patient cheer up, that an overactive patient go sit down and be quiet, or that a withdrawn patient initiate and carry through group activities simply places the patient in the position of having failed again. Failure causes anxiety in persons already insecure.

Insisting that a depressed patient cheer up, that an overactive patient go sit down or that a withdrawn patient initiate and carry through group activities are examples of ________________________.

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Placing demands upon a patient that he obviously cannot meet.

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3. The indiscriminate use of medical and psychiatric terminology in front of patients can often produce anxiety. Such terminology identifies a person as a member of a select group and shuts out those who do not belong. It is thoughtless rejection of patients.

The indiscriminate use of medical and psychiatric terminology in front of patients can often produce anxiety on the patient because ______________________________.

//

It identifies a person as a member of a select group and shuts out those who don't belong.

//

4. No attention should ever be called to a patient's defect, failing abilities, peculiarities, or failures. If a patient wishes to mention them, accept them calmly and without criticism. In any personal relationships it is a wise rule to concentrate on the individual's strength.

If a patient wishes to mention or talk about his defects, failing abilities or peculiarities the specialist should:

a. Inform the patient that he is not interested in hearing about them.

b. Tell the patient that he should not talk about things like that.

c. Agree with the patient that he has many defects, failing abilities and peculiarities.

d. Accept them calmly and without criticism.

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d

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5. It goes without saying that threats, sharp commands, and indifferences to a patient's reactions have no place in the care of psychiatric patients or in the care of any patients.

The last guideline that is included in this section is to develop a realistic specialist - patient relationship. A major part of your job is to become aware of interpersonal relations and what that term means.

Throughout life we meet new people and we feel something about them; we communicate with them by our actions and with words, and we have an effect on them. In your job you will meet and work closely with many patients. It is of paramount importance that you become aware of yourself in terms of your effect on the patient and his effect on you. As human beings, you need to be liked, to be respected as a person and to be important to others. You also need recognition, appreciation, and reassurance. However, you are expected to meet these emotional needs other than through patients. With mentally ill patients, you must be prepared to give and to expect no return other than the pleasure of seeing patients recover. Above all, you must lead a balanced life and have genuine sources of emotional satisfaction other than your patients. Whenever you find yourself being critical of patients, defending or justifying yourself, demanding that patients treat you in a certain manner, or evaluating patient's behavior in terms of right or wrong, you are in danger of letting your own emotional needs take precedence over those of patients.

No response requested. I think the above paragraph more than adequately explains what is involved in the building of a therapeutic specialist-patient relationship. Of particular importance is the need for you and for all of us who work in this field to have outside interests and to lead as balanced a life as we possibly can.

When you have completed this portion of the booklet, review all areas and the instructor will give you the final quiz over this area of instruction.

Good Luck!!!!!

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

WORKBOOK 3ALR91431-I-10
February 1974

RECORDING OBSERVATIONS

SCOPE

You will have the opportunity to observe the patient in many situations, both day and night, when under stress and when relaxed. It is important that you learn how to write brief observation notes that are not full of technical jargon. We will show you what to observe and how to write observational notes in the video tape and workbook.

OBJECTIVE

State the principles and techniques of recording observation.

INSTRUCTIONS

This instructional program is a combination video tape presentation and workbook. You will accomplish this instructional package in Room 1026 of the Learning Resource Center. Read the information in this workbook and then view the video tape portion, then complete the exercises in this workbook. The AV Technician in 1026 will operate the video tape machine for you. If you need to view the video tape again, ask the AV Technician to rerun the video tape.

When this workbook is complete, return to the classroom where the workbooks will be checked by the instructor. A discussion of this instructional material will then be held in the classroom by the instructor.

INFORMATION

Before making observations, you should be aware of two factors. First, we should describe what is actually there and not what "ought" to be there, such as "bits" of specific behavior. An example of this is what we have studied about a withdrawn patient may almost fit this patient so you write down the symptoms of a typical withdrawn patient in place of factual observations. This is to be avoided; you have to be as factual as possible. The second factor is to keep in mind our own objectivity being watered down by our interacting with the patient and having a slightly bias attitude.

This supersedes WB 3ALR91431-I-9c, Mar 72

Designed For ATC Course Use

DO NOT USE ON THE JOB

OBSERVATIONS ON ADMISSION

When a patient is admitted, the signs and symptoms characteristic of his illness are more vivid and prevalent. It is important for you to be observant at this time as the patient decompensates his illness rapidly after being hospitalized. The information that you observe and record on admission is particularly helpful to the physician to piece together a picture of how the patient's illness is still ingrained in him during the admission procedure. If relatives accompany the patient, the physician wants to know how the patient interacts with them and what part this interaction has played in the patient's illness.

EYE CONTACT

When meeting someone, the first thing you look at automatically and unconsciously is his eyes; are they looking at you? Does the patient look at you when talking to you? Does he focus his eyes away from you when talking about particular uncomfortable situations? Eyes may appear sad, empty, sparkle or move rapidly when frightened. The disinterested, completely unaffected person may have a blank expression about his eyes. The mood and attitude of a person are frequently reflected in the facial expression of the patient. The patient may look happy, sad, angry, haggard, alert, bewildered, dissatisfied, and show interest or disinterest. Tightening jaw muscles or grimacing show signs of anger and pain inside. The person's lips may be firm or curl in resentment and separate in a pleasant smile.

The overall appearance may indicate the patient's progress or regression. It is important for you to use descriptive terms in writing observational notes.

SLEEP

Sleep habits are sometimes unnoticed but are a part of the patient's life. Does the patient go to bed early, stay awake late or awaken late at night? Must he be pulled out of bed in the morning and then have difficulty staying awake? A patient that awakens early in the morning should be watched for suicide ideas. Depressed patients may feel they cannot face another day and attempt suicide early in the morning.

Now that you have seen some areas of observation, let's turn to the characteristics of effective recording.

RECORDING OBSERVATIONS EXERCISE

Answer each of the following questions in the space provided or circle the correct response. 60% accuracy is required.

1. In the appearance of a patient, bizarre or gaudy dress would indicate a patient's ________________.

2. A sad or happy mood of a patient can be determined by his ________________ ________________.

3. The mental patient's behavior is inconsistent with his appearance.

   (True/False)

4. The flat affect indicates the behavior in a patient with a ____________________ expression toward others.

   a. elated

   b. sad

   c. suspicious

   d. neutral

5. In the video tape, the patient wearing the cowboy hat had a ________________ rate of conversation and the tone of his voice was ________________.

6. The patient wearing sunglasses had a ____________ ____________ of conversation and the tone of his voice was ____________________.

7. The patient sitting on the right hand side of the domino game in civilian clothes spoke ______________ in amount of conversation.

8. What was the content of the conversation of the patient in the cowboy hat?

   a. Made sense.

   b. Rambled from topic to topic.

   c. Dominated with Exorcist thoughts.

   d. Mostly suspicious.

ACCURATE

State all behavior; say exactly what the patient does or says. Use quotes; for example: "You all are against me" or "Nobody understands me." For behavior: Sgt Jones ran into his room and slammed the door.

DESCRIPTIVE

Be brief and use simple English rather than long winded statements. Include all important details by using concrete illustrations. If a patient becomes violent and starts smashing the dishes, report just that instead of stating the patient appeared to be hostile.

OBJECTIVE

Be aware of your own prejudices and do not let them affect the actual observation.

MECHANICS

The mechanics of writing means to write legibly or print in ink. Record as soon as possible and in sequence of events happening.

Continue now to view the video tape and complete the Recording Observation Exercise.

9. What persecution did the patient in sunglasses express?

10. In the mechanics of writing, you should write legibly or print in ink and __________________ and _____________________ every report.

When you have completed this workbook, have the instructor check it for accuracy.

STUDY GUIDE AND WORKBOOK 3ABR91431-2-I-11

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

THERAPEUTIC ENVIRONMENT
and
THE PSYCHIATRIC TEAM

July 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

SW3ABR91431-2-I-11
July 1975

THERAPEUTIC ENVIRONMENT
AND
THE PSYCHIATRIC TEAM

OBJECTIVES

1. Describe the characteristics of a mental health unit which create a therapeutic environment.

2. State the purpose and duties of the psychiatric team.

INTRODUCTION

Many changes have taken place in the treatment of mentally ill people since the days of chaining them to a bed. One of the biggest improvements has been the environment in which a patient is placed. The prison-like atmosphere in state hospital is slowly becoming obsolete; paving the way for an improved method of treatment --the therapeutic environment. You, as Psychiatric Ward Specialists, are a very important element of the therapeutic environment.

STUDENT ASSIGNMENT

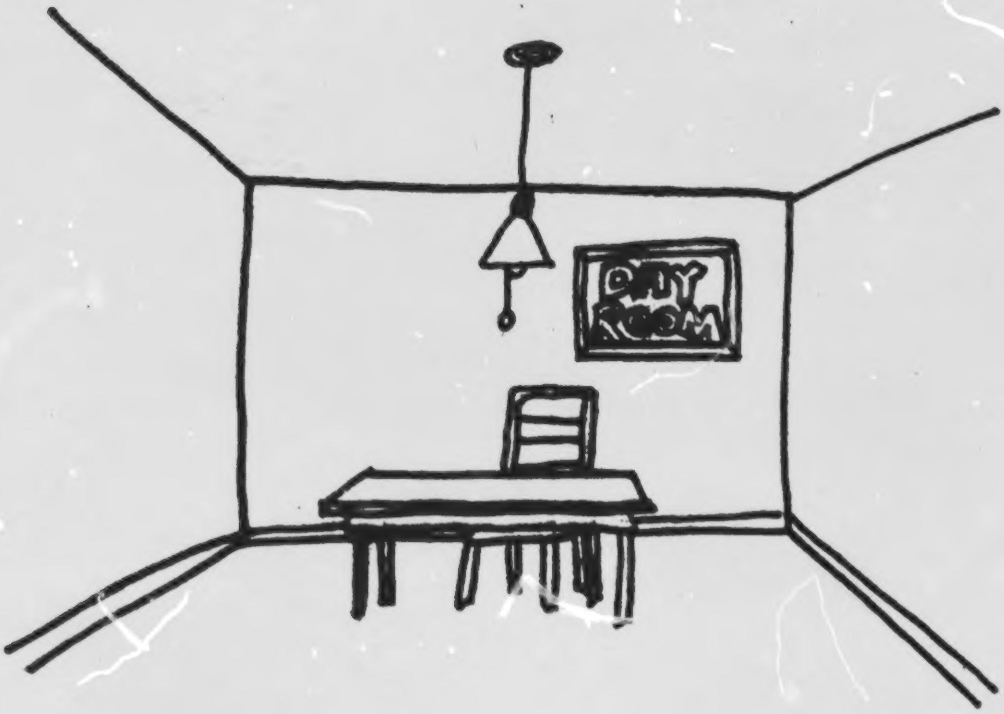
1. Read chapter 9, "The Patient and the Mental Hospital," Textbook for Psychiatric Technicians, pages 126-139.

2. Read this Study Guide and Workbook and answer questions at the end.

This supersedes SW 3ALR91431-I-11, November 1974

DEVELOPMENT

A therapeutic environment is one in which the psychiatric team deliberately employs all physical and interpersonal elements within a given psychiatric unit to accomplish for their patients the prescribed goals they know to be helpful.



Tearing the above definition apart, let's look at the phrase... physical and interpersonal elements... With this we are referring to every physical part and interpersonal entity that are found on a psychiatric unit. For example, the color of the walls, the odor, the furniture, the heat and light, the temperature and many others are part of the physical environment. Imagine the effect it would have on a depressed patient who is living on a ward that is very drab in appearance. It is doubtful this patient would have much motivation for improvement. Many times however, the physical environment is not in many ways therapeutic. For example, there are a few state hospitals that have no air conditioning, some have very poor heating mechanisms, and others are very ugly and rundown in appearance. Due to lack of funds these things are not remedied; therefore, many times the physical environment is not as therapeutic as it should be.

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Even though the physical environment is a very important part of any psychiatric unit, the interpersonal relationships within the unit hold a somewhat higher echelon of importance. These relationships range from staff to staff, staff to patient, and patient to patient. The interpersonal communication can be a potent behavioral influence, both positively and negatively, and verbal communication is a major psychotherapeutic treatment device. You, as a therapist, can function more effectively if you know what and why we are communicating to the patients, as well as comprehending what the patient is communicating to you. On the patient's level, if he can communicate and understand the staff, then this will enhance his feelings of security and of being accepted. It is believed that the more that is known and shared about a patient, his behavior and the events that effect his life, the more effective will be his treatment. This approach is the backbone for a technique known as moral treatment and by an approach termed milieu therapy, which was introduced into the US by William C. Menninger. In milieu therapy, the team leader (psychiatrist) prescribed a particular approach to be taken by the members of the staff engaged in working with the particular patient. These members include anyone in contact with the patient from occupational therapy to the nursing staff. Therefore, making the milieu not only involves the doctor-patient relationship but an extension of this to include all the staff in contact with the patient.

In the definition of a therapeutic environment the concept of the psychiatric team was mentioned as the individuals who employ all the elements of an environment to help the patient reach his prescribed goals. Therefore, the whole ward climate is dependent to a large degree on the personnel who work on the unit. The team approach is essential for the accomplishment of the goals the doctor has prescribed for a patient. The treatment of a patient begins with his initial contact with the staff. The staff must be oriented to patient needs, alert, understanding, communicate within itself, hopeful, interested, and friendly if this patient is to receive all the possible attributes of a therapeutic environment. When the doctor sets prescribed goals for his patient, the staff must understand these goals and work as a team to help the patient achieve the goals. For example, let's say that Doctor Loonie has a patient who believes he has a worm running around in his head. This patient talks about the worm frequently and at many times tries to let the worm escape by standing on his head. Doctor Loonie believes the best approach with this patient is not to discuss the worm in any way. When the patient stands on his head, ignore this behavior until he stands back on his feet, then do some sort of activity with the patient, such as take him for a walk. Doctor Loonie gave this approach to the psychiatric team during a team meeting. The day shift followed the Doctor's orders very explicitly. When the patient got off his head and stood on his feet, one of the day staff would take him outside or play cards with him, trying to reinforce the appropriate behavior. The evening shift's performance was the stumbling block for this particular treatment plan. They found it very amusing that this patient had a worm in his head. When he stood on his head they would reinforce

the patient by asking if the worm had crawled out yet, or if they could help him look for the worm. Thus we have an anti-therapeutic situation, creating much confusion and ambivalence for the patient and defeating the effectiveness of the psychiatric team. Can the patient improve? Of course not; in fact this may be so confusing and anxiety-creating for the patient that he may regress back to an earlier state or become even more delusional.

With the definition of a therapeutic environment in mind, let's look at some of the characteristics, both physical and interpersonal, that are found in a therapeutic environment.

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Immediate Needs

Meeting the immediate needs of patients is a very important element of the therapeutic environment. Patients need food, clothing, sleep, exercise, and medical care. You, as a specialist, have to provide and make these needs available for the patient. Two of the most important of these needs are rest and adequate nutrition. You have the responsibility to see that patients are physically comfortable, lights are low, and the room conducive to sleep. Many things keep a patient from rest and sleep, such as hospital noise, fear of other patients, anxiety, homesickness and preoccupation with his illness. You need to understand the patient's problems in sleeping or resting and then try to help him obtain rest by using various therapeutic techniques. For example, a paranoid patient in an anxious state may have the delusion that the guy next to him has a knife and will kill him if he closes his eyes. Recognizing this problem, you could move this patient into a room by himself until his delusions are not as prominent. Another important responsibility of the specialist is meeting the nutritional needs of the patient. Encouragement and assistance must be given to those patients who are poor eaters or who refuse to eat. For example, if you have a severely depressed patient, he may feel it is useless for him to eat. Therefore, you may have to sit down with him to eat, or stimulate this patient in someway to feed himself.

Exercise is also an important physical need. Many of the patients will require a long hospitalization in which their physical condition and vitality will diminish unless they exercise. Usually, each hospital has a recreational department which stimulates patients into all types of recreational activities. But many times the older or more ill patients are left out because the activities are too fast or too confusing for them. Therefore, there is a need to help them obtain some exercise on the unit level. For example, you are working with a severely withdrawn schizophrenic. Naturally this patient cannot play baseball with the rest of the patients who are not as mentally sick. So, you may take this patient out for a walk or have him do some simple exercises on the ward, giving him a chance to relax himself through exercise. Allowing a patient to exercise serves as a means to stimulate his appetite, improve his circulation, aid in elimination, and promote rest and sleep.

Hygienic Care and Comfort

Most hospitals are set up in such a fashion that many patients occupy the same room for sleeping and share the same toilet and grooming facilities. As a result, there has to be a large emphasis placed on the cleaning and sanitary conditons of each psychiatric unit. Many hospitals have the patients do their own cleaning of the wards, which gives them a little more responsibility and is therapeutic in nature. It is important though that the patients are supervised during the cleaning so that the unit is assured that it is being cleaned properly. For example, a severely psychotic patient may attempt to use the brush he cleaned the toilet with on the sink.

TOILET BRUSH
CLEAN

Where there are a number of people sharing a unit together the chances for disease are higher making the need for sanitary facilities greater.

Consistency

This is a very important characteristic of any therapeutic environment. This concept was mentioned earlier in the discussion of the psychiatric team and the example of the patient with a worm in his head was given to show inconsistency on the part of the staff. One of the primary reasons for using a team approach for a patient is to inform the staff of the goals for this patient, resulting in each staff member reacting and treating the patient in a similar fashion. Thereby, giving the patient a consistent, less confusing treatment while in the hospital. Mentally ill people tend to overreact to any form of change by increased tension, confusion, and anxiety. Whenever a new staff member comes on the ward or there is a change in the routine of patient activities or a change in rules and regulations on a unit a patient may become a little more anxious or confused. Ways of providing consistency for patients is by having a team approach, formulating a set of rules and regulations and follow them, start and end patient meetings on time, and post the weekly schedule of activities for the patients.

Spiritual Support

Most all psychiatric hospitals have available ministers or chaplains who aid in giving spiritual support to any patient who expresses this need. It is important for a patient to realize this is available for him for a number of reasons. It gives a patient a feeling of security and comfort to know that these men are around and that they will talk to them whenever the patient desires. Many psychiatric patients are burdened with feelings of guilt about their behavior and need to feel that spiritually this has been understood.

Therapeutic Activities

Any activities in which patients take part have to be supervised in such a way as to protect the patient from injuring himself and others. In this we are not just talking about recreational activities, but all types of activities such as cleaning the ward, eating and even shaving. This, however, depends upon how sick the patient is. A person with a character disorder would resent you supervising his eating or shaving and this would be of no value for him since he is in contact with reality. But a severely schizophrenic patient may be unable to eat or shave himself in which you would assist him so that he would not injure himself or others. A suicidal patient should be observed closely while eating or shaving so that he does not confiscate the equipment to use on himself later. Many hospitals use some type of protector on the windows, usually a screen, along with different types of unbreakable glass. At all times dangerous equipment should be controlled to protect the impulsive or suicidal patient from hurting himself or other patients.

Communication

The importance of communication between members of the psychiatric team has previously been emphasized. There is also a great need for communication between staff and patients. Patients need to know what is happening, what is expected of them, what to do and what not to do. On many wards bulletin boards are used where posters of coming events are posted, daily schedules are found, copy of rules and regulations and work details are all posted. Patients need to feel free to ask questions and know that the staff will listen and communicate with them. A patient is oriented when he arrives on the unit, not only by the staff but also by other patients. By doing this you communicate to him that he is a part of the community and he will know what is expected of him. This will help eliminate many of his fears and apprehensions about being on a psychiatric unit. Being oriented by another patient about patient duties and responsibilities, he will develop a sense of group belonging to the group

and develop the feeling people are there to help him.

Acceptance

The part acceptance plays in a therapeutic environment is vital. Before any type of a therapeutic relationship can develop between staff and a patient, the staff has to accept the patient for what he is. Otherwise, if they resent the patient for his previous behavior, then their attitude will reflect this in their relationship with this patient. It is important that a patient realize that his behavior is accepted; this does not mean that you agree with his behavior and that you do not expect him to attain more appropriate behavior. What it does mean is that you realize for the present time that this patient's behavior is a result of his problems and as the patient receives more psychotherapy you will expect him to find more appropriate ways to handle his emotions. For example, there is a lady in a state hospital that becomes physically violent when she is upset. Naturally, the staff had to control her by the use of a physical restraint, but at the same time let her know that they understood why she was acting this way. The staff showed their acceptance of this lady by talking to her when she was restrained, giving her support and reassurance and helping her develop new ways to control these violent moods. Many months later this lady began to feel these violent moods come over her and would ask for the weight room in the recreational department to be opened. She would then go into the room and lift weights, throw the medicine ball, hit the punching bag and later walk out cool, calm and collected. She had learned to control her behavior in a more acceptable manner. The patient should be accepted as an individual who has rights, opinions and needs similar to our own.

Permissive and Democratic

A therapeutic environment must be permissive enough to give patients opportunities for personal expression. He is encouraged to test his attitudes against those of others so that his ability to meet his needs outside the hospital will be increased. The issue of authority raises much trouble on some psychiatric wards. Some staff believe they are there to police the patients and make them perform exactly as they want them to. This is a detriment to the environment and is definitely antitherapeutic. No feelings of trust or understanding are felt within a patient and he may even see his situation as hopeless. Patients need to have as much freedom as possible, to try out new approaches to behavior, new attitudes about life and new ways of making friends. If this is blocked by a police-like atmosphere, then his attempts are thwarted, resulting in frustration. The trend today is set up a hospital community where staff and patients are closely associated and the usual boundary between staff and patient is blurred by giving patients a share in decision-making. Meetings are held where patients are encouraged to take parts as equals and as therapists for one another. The atmosphere is permissive, but at times the staff asserts authority in order to protect the functioning of the ward. Patients should not have a feeling that they can completely control or take over the ward. Instead they should feel that what they say and do about matters of the ward have a big influence in the way the ward will be operated. They should feel that they and the staff are responsible for the ward and together will set up a program that will be beneficial to all members. Many hospitals are using a patient government program as one means of displaying a permissive attitude and giving patients a democratic way of handling ward matters.

Harmonious

The last characteristic of a therapeutic environment that we are going to discuss is centered around harmony. Sometimes on a unit you find a staff that has many conflicts among themselves. For example, one staff member may not like another, or the day shift staff is jealous of the evening shift staff. It would not be so detrimental to the environment if these situations could be kept away from the patients, but usually this is not the case. Patients pick up the conflicts or may even enter into them, choosing the side of his favorite staff member. Immediately this hampers the whole therapeutic community. Patients see the staff not working together and many of the characteristics we have so far talked about are ineffective. To some patients this causes increased anxiety; first thinking of the staff as his source of help and then seeing that they cannot even work together. Granted, it is hard for a person to like everyone, but it is not too difficult to be mature enough to work effectively with a person even though he is not your favorite. It is important to remember that you, as a specialist represent a model to patients. They think of you as a person who has control and mentally healthy. If you prove them wrong, then they lose confidence in you and their situation.

We have looked at one of the most important aspects in the treatment and care of the mentally ill patient--the therapeutic environment. A patient is on a psychiatric unit for help and it is your responsibility to make this help available and effective.

QUESTIONS

In your own words, explain your role as a Psychiatric Ward Specialist in creating a therapeutic environment.

THERAPEUTIC ENVIRONMENT
QUIZ

INSTRUCTIONS: Circle the right answer. You must answer a minimum of seven correctly to receive a passing score.

1. Milieu therapy involves all the staff that comes in contact with the patient. True or False.

2. A therapeutic environment is only concerned with the physical surroundings of the patient. True or False.

3. Immediate needs include such items as food, sleep, exercise and medical care. True or False.

4. Hygienic Care and Comfort are not involved in the therapeutic environment. True or False.

5. Consistency is a very important characteristic of any therapeutic environment. True or False.

6. Psychiatric hospitals do not allow spiritual support for patients because the patients don't need it. True or False.

7. Therapeutic activities means activities where the patient can't hurt himself or others whether it is an activity at the gym or a simple activity like shaving. True or False.

8. Communication between members of the psychiatric team is important, but communication between the staff and patients is of little concern. True or False.

9. Before any type of a therapeutic relationship can develop on the ward, the staff has to accept the patient for what he is. True or False.

10. A therapeutic environment should not be permissive and democratic because the patients can't handle personal expression or freedom? True or False.

11. The harmony of the staff has an influence on the well-being of the patients. True or False.

THE PSYCHIATRIC TEAM

OBJECTIVES

1. Define the psychiatric team.

2. State the prupose of the psychiatric team.

3. List the duties of the team members.

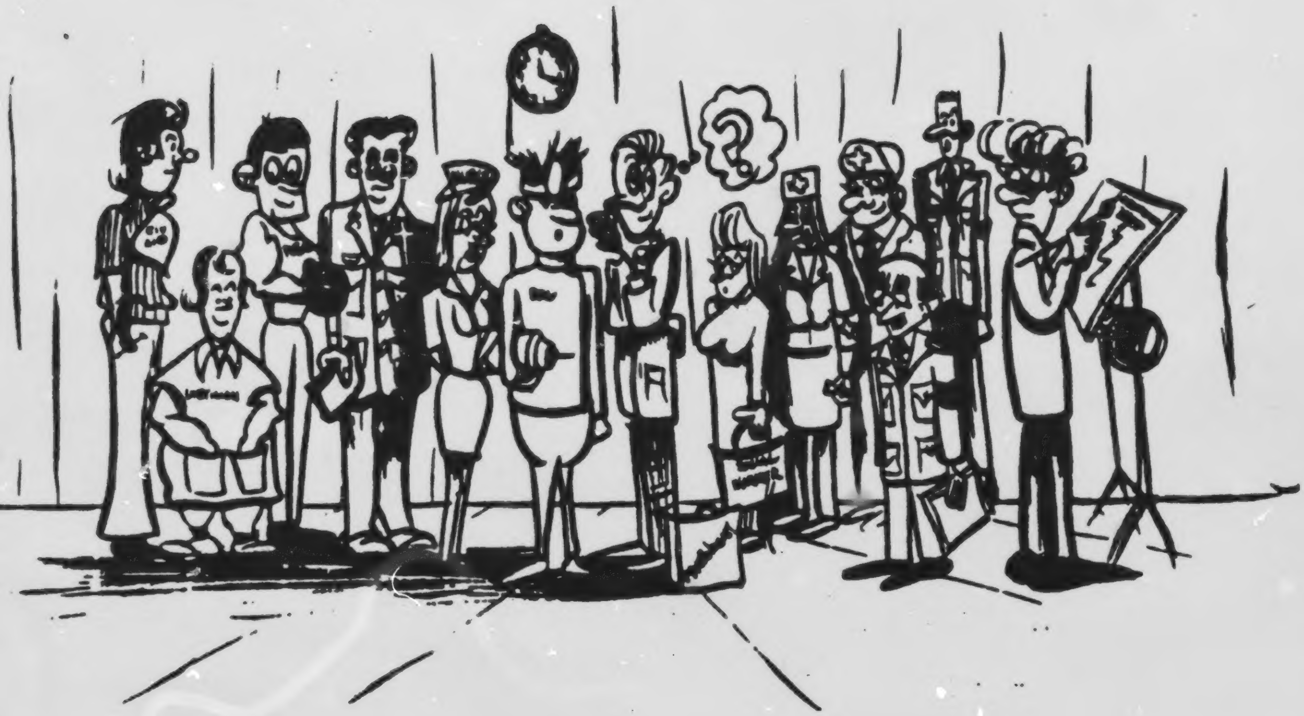
INTRODUCTION

Every team effort is directed towards the achievement of some goal. For the Apollo astronauts, the goal was landing on the moon; for the Pittsburgh Pirates, the goal was winning the world series. These goals were achieved because of the high morale, cooperation and contribution of each member of the team.

The same effort is essential for the members of the psychiatric team if we are to achieve our goal--the patient's recovery. Take care for the patient cannot be provided by any single individual. It can only be provided through the combined effort and contribution of each member of the psychiatric team. This is the reason the psychiatric service exists; this is the reason the psychiatric team has been organized.

DEVELOPMENT

The Psychiatric Team is a group of professional and nonprofessional people, who by sharing responsibilities and by working together in close cooperation, give the best of care and treatment to psychiatric patients.



PURPOSE OF THE PSYCHIATRIC TEAM

There are four main purposes to having a psychiatric team; we shall examine each of the reasons and see how each affects the specialist.

CONTINUITY. The psychiatric team offers continuity in all aspects of treatment and care of the patient. All of the care of the patient is well planned and coordinated. The care of the patient follows guidelines set down by the doctor and each member of the team is responsible for following these guidelines and continuing the treatment. This also means that messages from the doctor to the rest of the staff will be passed on accurately from doctor to nurse to technician to specialist.

CONSISTENCY. Every member of the team has a differenct duty to perform. Their central duty is to treat the patient yet all go about this in ways specific to their job description. All members of the team are consistent (uniform; in agreement with) in their approach in meeting the needs of the patient. This means that if a patient was diagnosed as suicidal every member of the staff would be consistent in their approach to him.

AVOID DUPLICATION. Each member of the team is aware of what needs to be done in treating a patient. Each team member is aware of the duties and

and responsibilities of the other team members and therefore in the ideal situation there is no duplication of tasks. If the specialist is supposed to take a patient's blood pressure at 1800, the rest of the team will not need to ask if it has been done, nor will they repeat the process. By avoiding duplication the patient is not as confused as he could be if the same treatments were being done over and over to him by a staff which could not rely on its team members.

BETTER SERVICE. By using the team approach we avoid the hit-and-miss way of treatment. The team concept is designed, as is the whole hospital, to offer the best possible service to the patients. Through using the team approach there is better communications between patient and staff and the patient receives better service.

DUTIES OF PSYCHIATRIC TEAM MEMBERS

1. Psychiatrist (Captain through Colonel)

   a. Team Leader
   b. Training of others.
   c. Specialized (Completion of 1 year internship in speciality), after completion of Doctor of Medicine degree.
   d. Examines, diagnoses, and treats mental illness
   e. Prescribes and evaluates therapy
   f. Serves as consultant on psychiatry
   g. Administration

2. Psychologist (Clinical - 2Lt through Colonel) (Master's degree in Psychology, one year supervised successful experience as a clinical psychologist after completion of formal school.)

   a. Training
   b. Administers and interprets psychological tests
   c. Psychotherapy
   d. Research

3. Social worker (Psychiatric - 2Lt through Colonel) (Master's degree in social work from accredited school a minimum of 12 months experience in Psychiatric case work)

   a. Training
   b. Interviews
   c. Intake and histories
   d. Liaison between hospital and outside world, expecially that which pertains to military.
   e. Therapy

4. Nurse (Psychiatric - 2Lt through Colonel) (Graduate of a 2 year accredited school of nursing and a minimum of 12 months experience in psychiatric nursing. Also certified as a registered nurse.)

a. Training
b. Plans nursing care
c. Effective ward communication
d. Supervises ward personnel
e. Evaluates quality of care
f. Administers medications and participates in therapies

5. Red Cross Recreational worker (Bachelor's degree)

a. Movies and games
b. Patient outings
c. Shows and parties

6. Red Cross Social worker (Bachelor's degree)

a. Communicates between patient and family
b. Financial aid
c. Personal items
d. Works closely with Psychiatric Social worker

7. Chaplain (1Lt through Major) (An undergraduate and Bachelor of Divinity degree are desirable. Mandatory requirements are two years experience and ordination and ecclesiastical indorsement by a recognized religious denomination).

a. Training
b. Works closely with psychiatric staff
c. Religious support and guidance

8. Recreational Therapist (may be specialist, technician, officer)

a. Organizes activities

(1) In hospital and on grounds
(2) On base
(3) Off base

b. Instructs patients

9. Occupational Therapist (2Lt through Colonel) (Bachelor's degree and completion of O.T. Course plus a minimum of 12 months experience prior to commission.)

a. Training
b. Initiates therapy as prescribed by physician
c. Urges patients to express feelings through O.T. projects

10. Dietitian (2Lt through Colonel) (Bachelor's degree and dietetic internship, a minimum of 12 months experience in hospital food service.)

   a. Training
   b. Schedules meals to meet patients needs
   c. Diets
   d. Prepares food for patient's parties and picnics

11. Technician (TSgt through MSgt) (Qualification as a Psychiatric Ward Specialist is mandatory plus experience in performing or supervising functions such as psychiatric patient care and rehabilitation.)

   a. Training
   b. Wardmaster and NCOIC
   c. Administration (medical, supply-expendable and non-expendable)
   d. Coordinates activities on and off the ward
   e. Supervision and training of enlisted men.

12. Specialist (Amn through SSgt) (Knowledge of personality development and mental illness; psychiatric nursing and treatment techniques; medical terminology; use and maintenance of therapeutic equipment, and principles of medical ethics. Experience in caring for psychiatric patients profile of S-1, and a minimum aptitude of General 60 is mandatory.

   a. Training
   b. Assists in nursing care
   c. Maintains a safe, clean and pleasant ward
   d. Escorts and safeguards patients
   e. Observes and supervises patients during activities
   f. Reports and records observations
   g. Creates a healthy environment for the patients.

13. Others: Civilian Aid (nonmilitary subprofessional), Ward Secretaries or consultants in other areas of the hospital

QUESTIONS

1. Match each term in Column A with the correct definition in Column B.

COLUMN A - TERMS

_____ a. Clinical Psychologist

_____ b. Red Cross Recreational Director

_____ c. Technician

_____ d. Dietitian

_____ e. Recreational Therapist

_____ f. Psychiatrist

_____ g. Civilian Aide

_____ h. Specialist

_____ i. Chaplain

_____ j. Psychiatric Social Worker

_____ k. Occupational Therapist

_____ l. Professional Nurse

_____ m. Red Cross Social Worker

COLUMN B - DEFINITIONS

1. Examines, diagnoses and prescribes treatment for the mentally ill patient.
2. Plans nursing care for patients; instructs, supervises and evaluates duty performance of subordinates.
3. Conducts and directs investigation of cultural and emotional background of military personnel for use by the psychiatrist in diagnoses and treatment of the patient.
4. Interviews patients, administers and interprets appropriate psychological tests and prepares psychological consultation reports for the phyciatrist.
5. Provides religious services and administers chaplain activities. Provides spiritual ministrations to the sick, confined, bereaved and the dying.
6. Instructs patients in techniques of performing arts and crafts as a therapeutic measure to lessen mental and emotional strain and motivate the patient towards a more normal pattern of living.
7. Directs the development of nutritionally balanced menus; inspects and evaluates food preparation and service to patients and duty personnel in accordance with dietetic standards.
8. Obtains medical and social data for use by the medical staff; assists with urgent communication for the patient and family. Informs patient's family about patient's condition.
9. Conducts medically approved reaction programs in military hospitals; provides professional recreation services for patients.
10. Assists professional staff in the treatment of psychiatric patients. Observes and records patient's behavior.
11. Assists in care and treatment of psychiatric patients; supervises psychiatric ward activities and personnel.
12. Nonmilitary subprofessional who assist in the care of psychiatric patients.
13. Supervises daily recreational activities of patients. Provides and manages recreational equipment.

2. What is the psychiatric team?

3. What are the purposes of the psychiatric team?

4. What effect does the relationship of the psychiatric technician with other members of the psychiatric team have upon patient care and welfare?

10-12

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-1
June 1975

PROTECTIVE MEASURES

OBJECTIVES

After a review of the purposes and methods of protective measures, correctly apply five of the manual holds on a simulated patient.

INTRODUCTION

You, the Psychiatric Ward Specialist, will be working with all types of patients. Some of these patients will be psychotic and may be unable to control themselves. You may have to assist in holding or restraining a patient. The responsibility of preventing injury to the patient is the responsibility of each team member. By protecting these holds and releases, you are less apt to injure the patient or hurt yourself.

INFORMATION

PURPOSE FOR RESTRAINTS

Protection of the patient is the main concern for all specialists. There will be times when restraints become necessary to obtain this protection. You will protect the patient from harming himself, as in suicidal gestures, protect the patient from others harming him or taking advantage of him, and protect others from the patient.

In some cases patients may have to be restrained for treatment. This may be for a few seconds or for longer periods of time. The treatment may be in the form of injections, lavage, gavage, or I.V.

The reason restraints are used more in the Air Force is due to air evacuation, which brings us to the third purpose for restraints - travel. Some acute patients are restrained for several hours when traveling by air evacuation, to reduce the possibility of an inflight emergency. Other patients are restrained for shorter periods of time when the ambulance is the mode of travel.

TYPES OF RESTRAINTS

1. There are three types of restraints. The first type is manual, which actually is physically holding the patient. This is usually used in conjunction with one of the other types of restraints, or all three types may be used in rapid succession, utilizing from one to six specialists. This type of restraint will be discussed in this study guide. Some of the important principles to remember here are (1) manual holds are only temporary and should not be used very long, (2) manual holds can cause injury to the patient, and (3) when possible, seek assistance when applying manual holds.

2. The patient may be given a chemical restraint in the form of a tranquilizer or a sleep inducer (I.M. or pill) to calm or quiet him.

3. The patient may also be placed in mechanical restraints. This is any type of a restraint with a locking or tying device. The leather cuffs and straps are the first choice of mechanical restraints. The seclusions room is also a form of mechanical restraint.

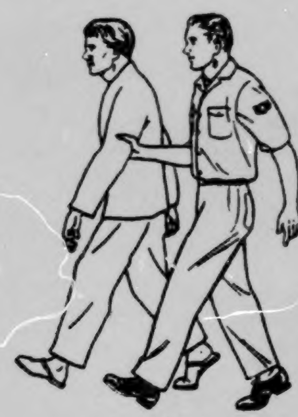
This supersedes SW 3ALR91431-II-1, November 1974.

Designed for ATC Course Use
DO NOT USE ON THE JOB

MANUAL HOLDS AND RELEASES

Arm Hold - to Escort Impulsive patients

Take hold of the patient's left arm just above the elbow. If he should try to hit you with his right hand, push his left arm forward toward his face, and the force of his swing will push you out of the way of his fist.

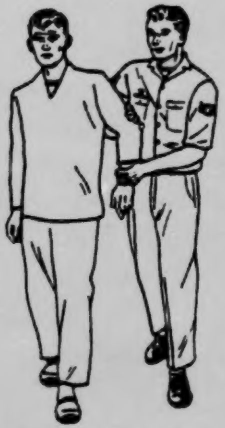


Arm hold

Elbow-Wrist Hold - to Escort a Small Mildly Resistive Patient

Take hold of the patient's left wrist with your left hand and his left elbow with your right hand. With your right hand raise his elbow, so that there is a right angle at his elbow. Lower his wrist a little. Pressure can be applied, if necessary, by pulling back on his wrist and ahead on his elbow.

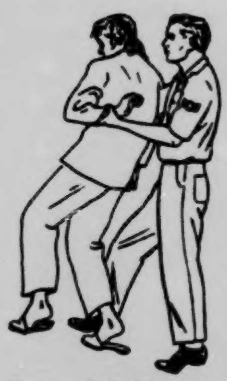
This hold can be painful to the patient if you exert too much pressure. Do not use this or any other hold to deliberately inflict injury to the patient. Always remember that the patient is sick, his thoughts and feelings may be inappropriate and different from yours.



Elbow-wrist hold

Arm Neck Hold #1 (Half Nelson) - to Hold and Move a Resistive Patient

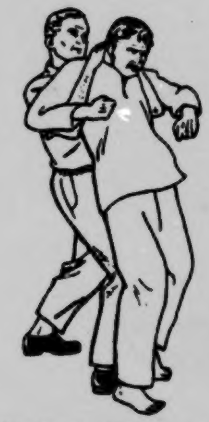
Approach the patient from behind. Put your arm up under his right arm and around the back of his neck. Take his left wrist in your left hand and bend it back on his spine to make an arm lock.



Arm-neck hold No 1

Arm Neck Hold #2 - to Hold a Strong and Assaultive Patient

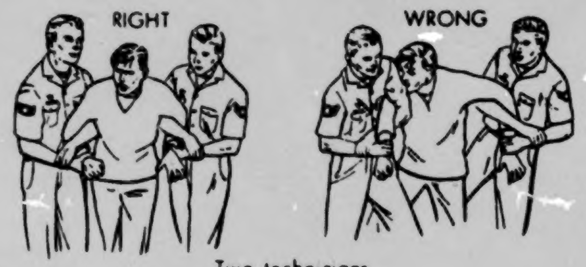
Approach the patient from behind. Slip both your arms under his and link your fingers lightly at the base of his neck. Some people might call this hold a "full Nelson." It is also helpful to place your knee between the legs of the patient and apply steady pressure. This will prevent the patient from kicking back.



Arm neck hold No 2

Two Specialist Hold - Used When Escorting a Strong and Assaultive Patient

The specialists approach the patient, one on either side. They put their arms nearest the patient under his arms above the patient under his arms above the elbow, and grasp the patient's wrist with their other hand. Then, each specialist takes hold of his own wrist with the hand that is through the patient's arm. Hold the patient's arm straight so that he cannot bend over to bite your shoulder.



Two technicians

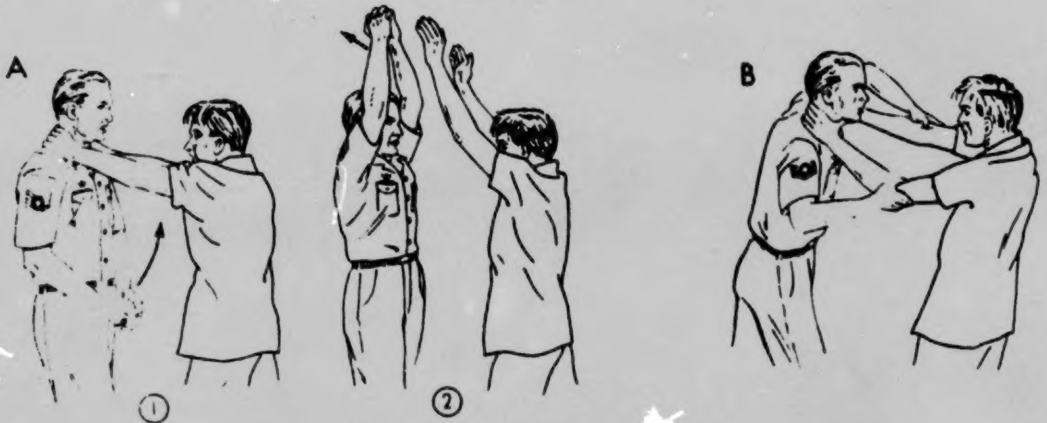
Four Specialist Hold - Used in Carrying a Patient

The four specialist approach the patient the same way as they do in the two specialist hold. The specialists hold the patient's arms and legs in the same manner as they do in the two specialist hold. The patient's legs are stronger than his arms; so, the stronger of the specialists should secure the patient's legs.

Choke Release - Two Methods of Breaking a Hold a Patient May Have on the Specialist

Clasp your hands between yourself and the patient, underneath is arms. Bring your clasped hands up suddenly between his arms. Be sure to follow through until your hands are well above your head. See steps 1 and 2 below.

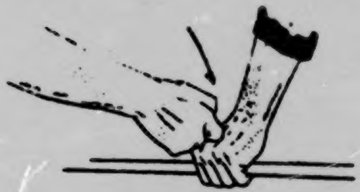
Grasp the patient's arm just below the elbow. Press your thumbs on the nerves found on the top of the forearm bones just below the elbow.



Choke release methods

Hand Release - to Release Grip on Objects

Press the knuckle of the second finger of your hand against the nerve that is in the groove on the back of the hand about an inch from the knuckle and between the second and third fingers.



Hand Release

Wrist Release - to Release Yourself From Patient Holding Your Wrist

Make your fist as hard as possible. Turn your wrists inward and press down. With a sudden snapping motion, draw your fists in, up, and then outward against the patient's thumb.

MANUAL HOLDS AND WHEN THEY SHOULD BE USED

Name of Hold	Used On
1. Arm Hold	Impulsive Patient
2. Elbow-Wrist	Small mildly resistive patient
3. Arm-Neck Hold No. 1	Resistive Patient
4. Arm-Neck Hold No. 2	Strong Assaultive Patient
5. Two Specialist Hold	Escorting Combative Patient
6. Four Specialist Hold	Carrying a Patient

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STUDY GUIDE 3ABR91431-2-II-2
June 1975

RESTRAINTS

OBJECTIVES

After discussion and demonstration of the procedures for application of restraints on a hyperactive patient as prescribed in SG 3ABR91431-2-II-2, students must correctly accomplish all steps on the checklist 3ABR91431-2-II-2a.

INTRODUCTION

You, the student, have already learned the purpose and procedures for manually holding a psychiatric patient. Apply restraints to a simulated patient. Often the occasion arises that manually holding a patient is not sufficient. In this instance the patient must be restrained either chemically or mechanically. The nurse will usually administer chemical restraints, and the specialist the mechanical restraints; so we will discuss the mechanical restraints since you the specialist will not administer chemical restraints.

This study guide also discusses the procedures for Air-Evacuation and ways to restrain patients on litters who will be using Air-Evac transportation.

INFORMATION

Purpose for Restraints (Mechanical Type)

Mentioned earlier in a preceeding workbook were the purpose for restraints; they are:

(1) Protection of the patient from himself, others, and protect others from him.

(2) Treatment

(3) Travel

All three types of restraints (manual, chemical and mechanical) can be used on a patient for any of the above reasons. Concentration in this study guide is on mechanical restraints.

This procedure is considered drastic and many hospitals have made claims to "no longer needing to use restraints", and yet a set of leather restraints can be found in almost any hospital. This treatment is one which is not used often yet is a needed treatment and deserves as much care and preparation as does other treatments.

The following are a list of important facts regarding the use and application of mechanical restraints.

Important Facts Regarding Restraints

This supersedes SG 3ALR91431-II-2, January 1975.

Designed for ATC Course Use

DO NOT USE ON THE JOB

a. To use or apply mechanical restraints you must have a doctor's order, except in an emergency when your team leader may decide to use restraints. Then immediately after, contact the doctor for an order.

b. Leather restraints are the best form of mechanical restraint, and may be used for long periods of time if properly applied. The seclusion room is most often used in conjunction with the leather restraints.

c. Never attempt to restrain a patient alone. It may cause injury to the patient as well as the specialist. Always seek assistance!!!

d. The heavy metal buckles on the leather straps make dangerous weapons. While in the process of restraining a patient, remember to always secure the straps; also make sure the restraints are in good condition.

e. Never enter the seclusion room or quiet room alone, for the patient may attack you in an attempt to get out.

f. While a patient is being mechanically restrained he should be checked frequently. Many patients try to fight the restraints and as a result become fatigued, which in turn elevates the B/P and increases pulse and respiration.

g. Any type of restraint may cause injury to personnel and patient. Care must be taken to use only enough pressure or leverage necessary to subdue the patient. You must never deliberately hurt the patient.

h. In the Air Force you will be seeing much more restraints than other brances of the service because of the USAF Air-Evac System.

Methods of Application of Restraints

The application of the restraints will probably take place with an aggressive patient The specialist must do certain things to insure that neither he nor the patient will be harmed during the procedure.

Following is a list of small steps used in restraining an aggressive or combative patient.

a. The specialist must always make sure his restraints are in good condition and that he has access to a restraint key. Being without the proper number of restraints and/or a restraint key is a situation which many specialists do not like to be in.

b. Make sure you have ample help before beginning to restrain a patient. One or two specialists is not enough help. Two specialists can do the job, but many times end up being hurt or hurting the patient. Four is an adequate number but the more specialists the better. Many times a show of force will deter a patient and he will calm down simply for seeing many specialists on the ward.

c. Make sure that the patient has given you ample reason to be restrained. Restraints are a last resort and if the individual can be talked to and restraints not used then the outcome will be much more enjoyable for all.

d. If all talking fails and the patient must be restrained then all specialist should grasp the patient at the same time. The patient can then be carried or escorted to an area away from the rest of the patients, placed on a bed and restrained.

e. The procedure for placing the restraints on the patient is as follows: (using 4 specialists) Largest specialist can lay across the patient's legs and immobilize them.

f. Two specialists hold the patient's arms and talk to the patient continually during the procedure trying to calm the patient down and explaining to him what is happening.

g. The last member of the group is responsible for placing the restraints on the patient. The content of a restraint packet and location where each goes on the patient is as follows:

QUANTITY	ITEM	WHERE APPLIED
2	Big Cuffs	Around Ankles
1	Long Strap	To Bed & Ankles
2	Small Cuffs	Around wrists
2	Short Straps	To Bed & wrists

h. The restraints are secured to the patient and the bed frame and then checked again to make sure they are locked.

i. The patient is then allowed to calm himself. A specialist should remain with the patient to insure the patient does not harm himself.

Remember that talking to the patient first may prevent him from being placed in restraints or manual holds.

Classification of patients for aeromedical evacuation

1. Class 1A or XA - an actively psychotic patient

    a. Hospital pajamas
    b. Sedation
    c. Restraints
    d. Litter

2. Class 1B or XB - a potentially psychotic patient

    a. Hospital pajamas
    b. Sedation
    c. Restraints accompany the patient (not applied)
    d. Litter

3. Class 1C or XC

    a. Class A uniform
    b. Ambulatory
    c. Hand baggage can accompany the patient

These classifications of patients for aeromedical evacuation are precautionary steps taken by the Air Force to reduce inflight emergencies such as patients that are actively psychotic who may become agitated and combative.

Other important facts concerning litter patient traveling Air-Evacs are:

a. Litters should be carefully checked for tears or holes in the canvas, cracked or broken poles, and damaged locks. This must be done before the patient is put on the litter. Make sure the litter is locked before the patient is placed on it. A litter that is damaged or unlocked is a safety hazard.

b. All patients classified as 1A, or 1B, should first of all be on the litter, not carrying it. It is acceptable for patients to pickup their beds and walk after they have been cured, but we do not think self-care should extend that far, that early. Also, all 1A and 1B patients should have taken their medications at least one hour prior to boarding the aircraft. This is not an option, this is a requirement. All litter patients should be in hospital garb, not uniforms or civilian street clothing. As funny as it may seem that litter patients arrive fully dressed, it happens just about every day.

c. Since 1 December 1972, a total of $5253 has been found on Class 1A and 1B patients. Psychiatric litter patients are not supposed to have any valuables with them and not more than $10 in money or negotiable instruments.

CONCLUSION

Restraining a patient is not a difficult task if it is done with skill and approached with the knowledge and belief that what is being done is for the good of the patient. If you the specialist are afraid then the patient will be afraid.

Remember that the Air-Evac System in the Air Force is one of the most organized and efficient systems in the military which depends upon your ability to adequately prepare patients to be carried on this system.

Chemotherapy (3) and Special Therapies (4) have been deleted in adapting this course for inclusion in the Trial Implementation of a Model System to Provide Military Curriculum Materials for Use in Vocational and Technical Education. These sections were combination audiovisual and workbook presentations. The audiovisual aids could not be reproduced and provided through this project.

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-5

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

PSYCHOTHERAPY

August 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

SW 3ABR91431-2-II-5
August 1975

PSYCHOTHERAPY

OBJECTIVE

a. Identify the principles of Psychotherapy and its role in psychiatric rehabilitation.

INTRODUCTION

Most people use or have used a form of psychotherapy sometime in their lives. Maybe they consoled a friend who had some type of problem or calmed a panicky child or just talked with his spouse about problems in their family. All this is a combination of supportive and insight therapy. Of course, there are types of psychotherapy that are not as simple to administer and are based on well established general principles of psychodynamics. As a psychiatric ward specialist you will have much contact with patients and their problems. You will have many opportunities to help patients discuss their problems and feelings through the medium of psychotherapy. Since you will participate in group therapy as co-leader or leader, you will need to know the basic guidelines and principles of group therapy so that you can function effectively in this area.

STUDY ASSIGNMENT

1. Read Chapter 11, "Therapeutic Activities and Special Therapies," Textbook for Psychiatric Technicians, pp. 153-168.

2. Read Study Guide/Workbook and answer questions at the end with 60% accuracy.

This supersedes SW 3ALR91431-II-5, July 1973

INFROMATION

PURPOSE OF TREATMENT

The definition of psychotherapy is an application of specialized techniques for the treatment of mental disorders or the problems of everyday adjustment. Before we actually go into the different kinds of psychotherapy, let's first look at the goals of this treatment.

Psychotherapy aims toward personality growth in the direction of maturity, competence, and self-actualization for a person with a mental illness. This involves the achievement of one or more of the following specific goals:

1. An increased insight into one's problems and behavior, so that one will know that he does have a problem and that his behavior is a result of the problem.

2. A better understanding of one's self-identity, or who he is.

3. A resolution of handicapping or disolving conflicts.

4. Changing undesirable habit or behavior patterns.

5. Improved interpersonal relationships and other competencies.

6. Changing inaccurate assumptions about one's self and the world he lives in.

7. Opening a pathway to more meaningful and fulfilling life experiences.

These goals are hard to achieve due to the fact that many of the patient's problems stem from faulty parent-child relationships, or the patient's life situation is such that any adequate occupational, marital or social adjustment is almost hopeless, even with the best pyschotherapy. It is unrealistic to expect a pyschotherapist to step in and in a few hours undo the entire past history of a patient and prepare him to meet a difficult life situation. However, a psychotherapist who has an inner drive toward the integrity and health of a patient, along with the unique ability to formulate a personal relationship with patients, can help a patient reach the goal of psychotherapy.

There are many different views of the techniques of psychotherapy. But, there are certain stages through which psychotherapy usually progresses. They are are as follows:

Creating a Therapeutic Atmosphere and Relationship

This includes the room in which the therapy session takes place, and the relationship between the patient and the therapists. Other factors like time, expense and responsibility are also elements of a therapeutic situation. A room that is quiet and conducive for discussion is an important part of the therapeutic relationship. The most important part of psychotherapy, however, is the relationship between therapist and patient. The therapist maintains a friendly and accepting attitude which reflects confidence in the patient, so that he can feel secure in discussing his problems. He must be able to express himself and feel that he is understood and safe in expressing his problems. The feeling of confidence and harmony which is established between the patient and therapist is refered to as rapport.

Emotional Release (Catharsis)

Catharsis is defined as the release of tensions and anxieties by reliving and unburdening those traumatic incidents which in the past were originally associated with the repression of emotions. In the permissive atmosphere of the therapeutic situation, the patient brings up his problems and expresses emotions that center around the problems.

As he "talks out" his problems, hostility, fear or other feelings of which he was totally unaware will come to the surface (Catharsis). This opens the way for the development of insight and actions toward solving the problems. A therapist may help a patient uncover these emotional feelings and tensions by using various questioning techniques, free association interpretation and, a professional therapist may even use hypnosis.

Insight

As a patient begins to express these repressed emotions and tensions, he also gains a good deal of understanding into his motivation and behavior. Self-understanding is highly important for successful therapy.

Personality Change

Now that a patient has gained some insight into his problems, he can more clearly understand his emotions, and why he acted and felt the way he did. He is then able to make changes in his behavior and attempt more appropriate adjustive measures. These changes may be major or minor in scope and may involve habits, social roles and other aspects of a patient's behavior. Often the first step to a change consists of positive action of a minor sort, such as learning to express hostility in socially acceptable ways, rather than keeping it bottled up. Then these positive actions gradually lead to competence and self-confidence.

Termination

After a patient has worked through his conflicts, the time comes for the termination of the therapy. This usually is no problem since the patient now feels more confident and able to get along on his own.

Now let's turn our attention to the different types of psychotherapy and the ones that you as a psychiatric ward specialist will be in contact with.

TWO GENERAL TYPES OF PSYCHOTHERAPY

When the therapist treats one patient at a time, the procedure is referred to as individual therapy. The emphasis being placed on the patient-therapist relationship. If the therapist works with several patients at the same time, this is a group psychotherapy. The emphasis being placed on the relationship of the patient to other members of the group as well as to the therapist. Individual therapy is more effective in working through deep conflictual material, such as conflicts centering around a parent relationship, while group therapy displays particular value in socialization. Through mutual sharing of problems and with the support and assistance from members of the group many common problems can be "worked through," and feelings of isolation removed.

Specific Kinds Of Individual Psychotherapy

SURFACE OR SUPPORTIVE THERAPY. It is a type of individual psychotherapy in which no attempt is made to go deeply into the patient's underlying conflicts. Instead an attempt is made to reassure the patient and to reinforce his present ego defenses. In many crowded or understaffed hospitals, this is the only type of psychotherapy the patient receives. Of course, this type is not too effective on patients who have deep conflicts but is effective on the patient whose ego strength and ability to adjust are fairly good, but overwhelming stress made him a psychiatric casualty. The excessive stress, rather than a deep pathological trend within the personality is the main cause of the difficulty.

NOW LETS TALK ABOUT YOUR MARRIAGE PROBLEMS

Surface or supportive therapy is the most frequent type of individual psychotherapy used in the military. Since most patients are only on the wards for a fairly short time, there is not time for types of psychotherapy that work on deeper problems of a patient and take a longer time to administer. As a psychiatric ward specialist, you will be using much surface psychotherapy in dealing with your patients. Helping patients with their problems-at-hand, and helping them to adjust to different life situations, such as marriage problems or problems with the Air Force, are many of the types of situations you will be helping the patients working through.

DEPTH OR DYNAMIC THERAPY. It is a type of individual psychotherapy that attempts to uncover and work through deep conflictual material. By exploring the repressed conflicts and bringing them to the conscious level, a patient can then learn to deal with them . This is a long term type of psychotherapy and the preferred type for long range benefit. For example, take a patient who is diagnosed as a homosexual. This patient may be admitted to a psychiatric unit for displaying this type of behavior. Surface psychotherapy will help this patient control the anxiety of the admission and keep him from a panic reaction, but unless this patient has some intensive psychotherapy and these unconcious conflicts are brought out and dealt with, he may still be struggling with his homosexual behavior after he is discharged from the ward. He may not have any behavior problems for a few months after discharge, but invariably this homosexual conflict will present itself again and he may even go back to the ward.

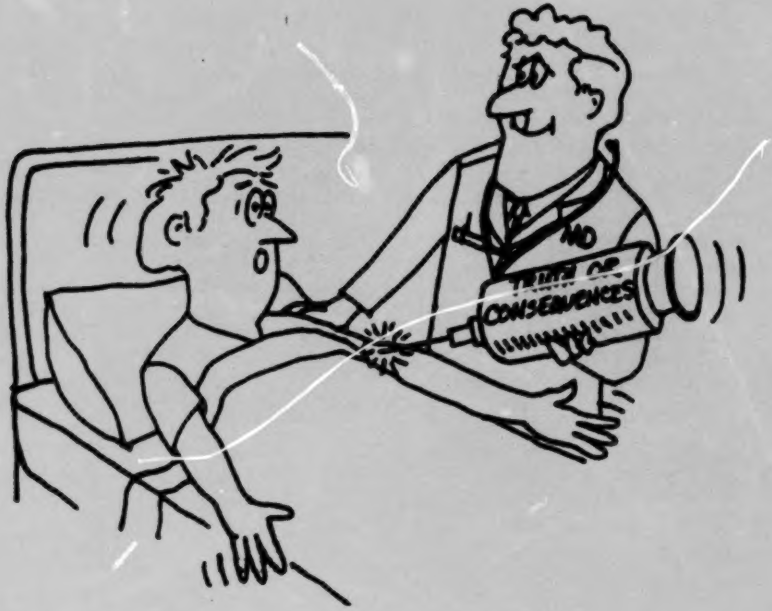
Two systematic approaches to psychotherapy that work deep within a patient's unconscious are client-centered and psychoanalytic psychotherapy. In client-centered psychotherapy (Carl Rogers) the primary aim is the removal of blocks that are causing frustration and the freeing of the patient to accept his unique self and to grow and change in his own natural way. The client-centered approach believes that human nature is basically good and that each individual has the capacity for constructive, self-directed change.

The other approach that was mentioned was the psychoanalytic approach, evolved from the work of Sigmund Freud. It is an intensive, long-term procedure for uncovering repressed memories, motivations, conflicts and helping the patient to resolve them. Freud believed that all of us repress certain painful or anxiety-arousing experiences, desires, and conflicts. As a result, we are often unaware of the real basis for our thoughts and behavior. In psychoanalytic therapy the principle procedure for uncovering such repressed material is free association. The patient is placed in a comfortable position and is encouraged to let his mind wander freely and give a running account of his thoughts, feelings and desires, whatever they may be. This free and uninhibited flow of associations leads to the gradual uncovering of underlying conflicts and emotional release. Then, by means of appropriate interpretations to the patient as to what his free associations have revealed, the therapist helps the patient to achieve increased insight into these underlying motivations and conflicts of which he was unaware. Another important procedure for uncovering unconscious motivation is by analyzing the dreams of a patient. When the patient is asleep, repressive defenses are lowered and forbidden desires or feelings may find an outlet in dreams. Of course, not all dreams can be interpreted and the meaning of a dream is not usually evident to the dreamer. Much more is involved with this form of psychotherapy, such as the transference that takes place between the patient and the therapist and the emotional re-education of the patient. Psychoanalysis is very expensive and takes a considerable amount of time.

" AND IF YOU DON'T PAY YOUR BILL BY THE FIFTEENTH, MR. BUMSTEAD, I SHALL LET YOU GO CRAZY ! ! !

In the military situation, you will see very little, if any, depth psychotherapy. There is just not enough time or staff to use the methods described above.

NARCOSYNTHESIS This is another type of individual psychotherapy. Introduced by J. S. Horsley in 1943, this treatment involves administering an injection of barbiturate drugs to produce drowsiness in a patient. The patient reclines comfortably on a bed or couch and is given an injection of sodium amytal or sodium pentothal to make him groggy and suggestible but not unconscious. The patient is then interviewed by a skilled therapists.



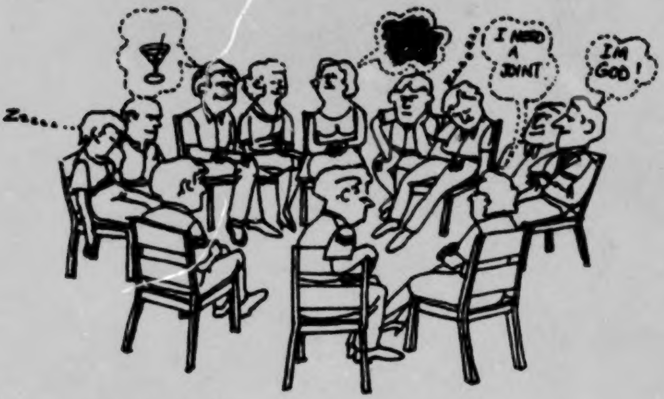
The value of the interview being that the patient may release pent-up emotions, or recover lost memories and by doing this, work through deep conflictual material. This is very effective for example, in removing paralysis or other symptoms of a conversion reaction. The therapist may also leave suggestions with the patient during the interview which tend to be carried out in his later waking state. During and following the interview the therapist aids the patient by means of suggestion interpretation and other techniques to bring forth the traumatic and conflictual material.

The military does use this form of psychotherapy when the situation arises. Especially in extreme forms of conversion reactions such as paralysis of a limb. Usually the interview is carried out by the physician and the psychiatric ward specialist assists him.

Group Psychotherapy

Several patients are handled by the therapist at the same time. The following are types of group psychotherapy.

HOSPITAL WARD MEETING (group discussion) It is a type of group meeting that brings all the patients of a ward together in a structured group activity for discussion purposes. This is not a group therapy, but more of a group discussion. It contains a large number of people and has different goals and purposes than the group therapy.



The chief purpose of the hospital ward meetings is to encourage the free expression of feelings. From the ventilation of feelings comes acceptance and understanding from other patients and the leader. The recognition that other people have similar problems diminishes feelings of isolation and encourages patients to look at themsleves. Ward meetings encourage patients to help one another through a mutual interchange of feelings and thoughts; an interchange that is not confined to the actual meeting but continues day and night in other activities on the ward. Ward meetings give patients opportunities to examine individual conflicts with other patients and to express their feelings about current ward problems and ward management. In these meetings hostilities are expressed about such things as food, ward discipline and rules, staff members and fellow patients snoring.

The ward meetings offer each patient a valuable experience in socialization with others. The patient can experiment with new ideas, new attitudes, new ways of expression and many other aspects of his personality that he needs to try out on society. By expressing these feelings along with the understanding and support from others, the ward meetings help a patient overcome the acute symptoms of his illness.

The ward meetings also are very helpful to the staff. They contribute significantly to a better understanding of the patients and lead to improved management. If the staff utilizes what it can learn from ward meetings, these meetings can play a beneficial part in feedback along with other forms of therapy administered on a ward. These meetings can help the staff see where the patients' problems lie and what goals they can set for the patients.

In the military, ward meetings are very frequent and very helpful. As psychiatric ward specialist, you will be directly involved with ward meetings and share responsibility in the promotion and effectiveness of these meetings. It is important that you acquire a positive attitude and encourage patients to attend the meetings. It should not be something a patient feels he has to attend, but rather something he wants to attend for his own well-being. If you do attend a ward meeting you should stay alert, watching patients' reactions and participate when you feel you can help. If something happens during the meeting that you feel is significant, you should convey this to the rest of the Psychiatric team so that all are aware.

GROUP THERAPY This is another form of group psychotherapy. This consists of a much smaller number of people who, through the hands of a skilled therapist, gain insight, resolve conflicts, gain self-acceptance, and enhance personality growth. It is primarily a social and psychological process in which an emotional re-educational and relearning experience can occur. Group therapy is concerned with both the conscious and unconscious conflicts of patients. In general, the goals of group therapy are as follows:

1. Improve reality testing

2. Aid in socialization

3. Foster the awareness of the relationship of emotional reactions to anxiety and defensive patterns of behavior.

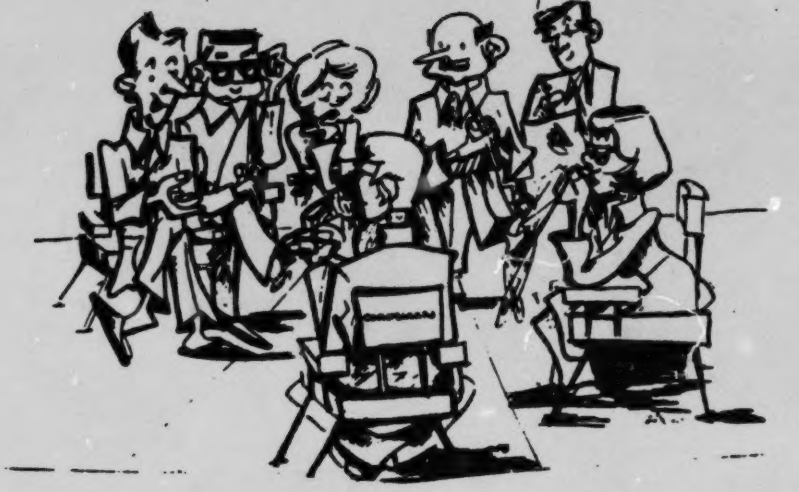
4. Provide motivation for continued improvement.

Group therapy can provide the mutual support, diminished feelings of isolation, the release of impounded anger and improve self-esteem. It helps modify the rigid conscience and diminishes feelings of guilt. It offers group members an opportunity to see that their reactions and feelings in a therapeutic group are similar to their reactions and feelings in other groups and that whatever emotional re-education and relearning they may achieve in group therapy can also be applied to their outside relationships.

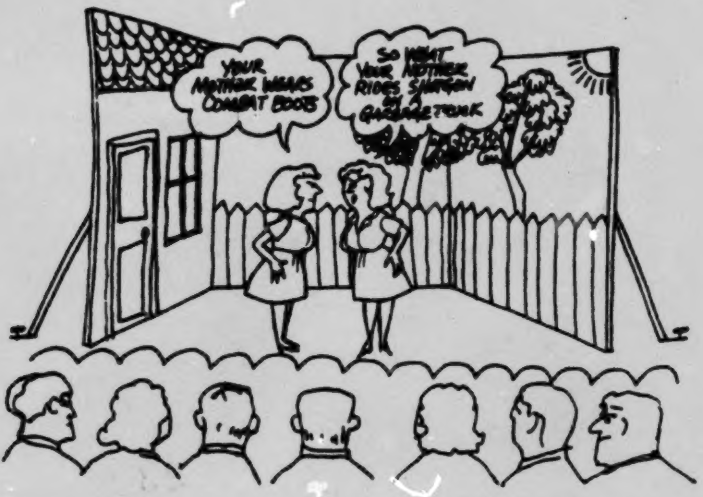
The therapist is an extremely important element of any group therapy. He must be interested and enthusiastic, letting the patients feel that he really believes in what they are trying to accomplish in the group therapy. His conduct in group therapy must create an atmosphere of acceptance and understanding, and indicate to the patients that someone is interested in their welfare.

In the military on the in-patient wards, a true group therapy is hard to find. Since patients are admitted and discharged rapidly, it is very hard to organize a dynamic group therapy. Instead, one may find many group therapy sessions that evolve around the discussion of the patients' personal problems. In out-patient clinics, group therapy is administered to military people and their dependents. These groups are small in number and the patients can attend for longer periods of time.

Group therapy is an outstanding form of psychotherapy and is becoming more popular with psychiatric installations. In fact, most all psychiatric facilities use some form of group therapy. There are many types of group therapies, each having its own methods and principles. We will study more about group therapy at a later time.



PSYCHODRAMA The last type of group psychotherapy we are going to study. This was developed by J. L. Moreno in 1921, when he observed the changes that occurred in people when they spontaneously acted out their personality problems. Psychodrama takes place on a stage, with the chief actors being the patient (protagonist or leading actor), the chief therapist (the director), other patients or assistant therapists (the auxillary egos), and the audience. A situation is given the patient by the therapist or by the patient himself, and this sets the outline for the drama. For example, the patient's husband has told her that he is in love with someone else and is leaving her, so this is the situation for the drama. The auxillary egos are assigned roles and the patient then begins to act out the scene spontaneously. One of the chief functions is to help bring out feelings and problems of the patients. The goal in psychodrama is to help the patient


YOUR MOTHER WEARS COMBAT BOOTS
SO WHAT YOUR MOTHER RIDES SHOTGUN ON A GARBAGETRUCK

achieve emotional release and become a more adequate, spontaneous, and creative person. In the process of psychodrama, the patient reveals a great deal about his personality organization--his motives, problems and typical ego defenses. It also helps a patient learn how to express himself easily and spontaneously and in meeting new situations effectively.

You probably will see very little psychodrama used in the military. This takes a lot of sessions and time, plus a very qualified specialist who has had training in psychodrama.

In this lesson, we have looked at many of the psychotherapies used today in mental hospitals around the world. You will be involved with some form of psychotherapy in your job as a psychiatric ward specialist. Consequently you should learn as much about the therapies as you can, thus making you more proficient as a specialist.

QUESTIONS

1. Define psychotherapy.

2. What are the stages through which psychotherapy progresses?

3. What are the two general types of psychotherapy?

4. Describe surface psychotherapy.

5. Describe the two approaches to psychotherapy that work deep within a patient's unconscious.

6. Explain how narcosynthesis works.

7. How does a hospital ward meeting differ from group therapy.

8. What is the chief purpose of the hospital ward meetings?

9. Explain the psychiatric ward specialist role during a hospital ward meeting.

10. List the goals of group therapy.

11. Why are there very few actual group therapies on in-patient psychiatric wards.

12. Describe how psychodrama works?

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

NURSING CARE AND APPROACHES - ANXIETY

August 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

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201

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

PT 3ABR91431-2-II-6
August 1975

NURSING CARE AND APPROACHES - ANXIETY

OBJECTIVE

a. Identify the patterns of behavior of patients displaying anxiety.

b. Given a case study on the anxious patient, design a plan of care which will identify the patient's problems and needs, and the appropriate nursing approaches necessary to cope with these problems.

INTRODUCTION

We are now going to study a group of psychiatric disorders whose chief characteristic is anxiety. This group is called the psychoneurotic disorders and in 1961 was estimated that over 10,000,000 people in the U.S. were suffering from a type of psychoneurosis. Over one half of all persons who go to doctors with physical complaints are found to be suffering from neurotic or other emotional disorders rather than organic pathology. Psychoneurotics are found among all segments of the population, regardless of intelligence or economic status. As a Psychiatric Ward Specialist you will be in contact with many psychoneurotics; therefore, it is important for you to understand this type of disorder so that you can give better nursing care.

INSTRUCTIONS

1. Read: Textbook for Psychiatric Technicians, pp. 169-196.

2. Answer the questions at the end of each section.

INFORMATION

CHARACTERISTICS

You have seen from the introduction that the evidence of neurotic development is high. As a PWS you will certainly have a considerable amount of work with neurotics in the coming years. Lets look at some of the personality characteristics that all neurotics have in common. Each of these stemming from immaturities, weaknesses, and faulty evaluations of themselves and their problems. These characteristics are as follows:

Inadequacy and Low Stress Tolerance

The neurotic sees himself as basically inadequate. This may be observed in the behavior of the neurotic who is very dependent on others and clings to them for support. It may also be seen in the neurotic who displays an exaggerated independence, in which he refuses help from everyone or tries to triumph over and dominate others. Often these underlying feelings of inadequacy are displayed in a search for a strong and vital marital partner who will make his life seem more secure and meaningful.

A neurotic also has a much lower stress tolerance than an adjusted person. By stress tolerance we are referring to a person's ability to function under stress; therefore, if one has a low stress tolerance it does not take much stress before it effects the behavior of this person. This low stress tolerance is attributed to a badly organized personality resulting from immaturities and distortions. As a result of lower stress tolerance and the feelings of inadequacy, the neurotic perceives many situations as threatening which to a normal person would not be so.

This supersedes PT 3ALR91431-II-6, August 1974

Anxiety and Fearfulness

Due to the amount of stress which the neurotic sees as threatening, anxiety is the key emotion the neurotic must deal with. Sometimes this anxiety is felt directly by the individual but in most cases the neurotic develops defenses for reducing his anxiety. These defenses are rarely adequate to handle the anxiety, so a considerable amount of anxiety and fearfulness still remains.

Tension and Irritability

Since the neurotic is overly anxious and afraid, he is continually alert for defensive action to protect himself from anxiety and is prone to overreact to minor annoyances which the normal person would take in stride. This leads to general body tension and an irritable person. Neurotics tend to deal with their problems in an emotional, rigid way, rather than with rational means.

Egocentricity and Disturbed Interpersonal Relationships

The neurotic is primarily concerned with his own feelings, his own ambitions and desires. He sees his life situation somewhat helpless and insecure and feels he is often fighting for his very life. Therefore, it is not surprising that he becomes very self-centered or egocentric.

When a person feels inadequate, is irritable and egocentric, then his ability to form satisfying relationships is greatly hindered. He becomes blind to the feelings of others and often makes unrealistic demands upon those around him.

Persistent Nonintegrative Behavior

As a result of the neurotic's overreaction to stress, he either experiences direct anxiety or resorts to the use of defenses which alleviate the anxiety but fail to cope with the stress. In either event his behavior is nonintegrative, meaning that his personality, composed of all traits and parts, is not working as a coordinated whole. He is using defenses that are self-defeating but tend to be self-continuing because they reduce his anxiety. The more the defenses reduce his anxiety the more stable they become. For example, take the 45 year old neurotic who is late for an appointment. When he arrives at the building where the appointment is, he finds it's on the 8th floor. Because this man has a fear of riding in an elevator he walks up 7 flights of stairs to avoid the anxiety associated with the elevator. This behavior makes him later for the appointment and very tired once he arrives.

Lack of Insight and Rigidity

Although the neurotic is aware of his symptoms and complains about them, he usually has little insight into the causes. Since the neurotic has built such a defensive behavior pattern to ward off terrifying dangers, he carries these patterns with him during the rest of his life activities, so as not to endanger this defensive structure. This makes him a rigid person by not being able to modify his defenses or handle problems in a flexible manner.

Dissatisfaction and Unhappiness

Due to all the factors above, it is clear why the neurotic would be dissatisfied and unhappy with his life. He tends to avoid struggles and challenges, and as a result denies himself a chance for increased self-esteem and confidence.

Psychological and Somatic Symptoms

The neurotic has a wide range of psychological and somatic symptoms. On the psychological level they experience anxiety, phobias, obsessions, compulsions, apprehension and combinations of these. On the somatic level we find tension, fatigue, indigestion, excessive sweating, heart palpitations, headaches, aches and pains experienced by the neurotic. Although there is no organic basis for these complaints, the neurotic often feels there is and focuses a good deal of hypochondriacal concern for them.

Keep in mind that not all of these characteristics are found in any given case. Neuroses are the result of a complex interaction of personality and stress factors, and the specific causes and expressions of neurotic reactions are different for each individual.

PSYCHOLOGICAL THEORIES

Now that we have looked at some of the general characteristics of the neurotic, let's turn our attention to some of the general causes for the psychoneuroses.

There is little evidence that heredity, constitution and other biological factors play any significant part in the development of neurosis. Many studies have been administered to find some biological coordination factor for neuroses, but the findings are not significant at this time.

However, several psychological theories have evolved and can be categorized under the following three headings:

Learned Maladaptive Behavior

The theorists in this group believe that all neurotic reactions came from maladaptive responses learned by reinforcement. For example, say a man has a fear of snakes that is causing him much anxiety when he is confronted with one. If, when he sees one, he runs away and rids himself of the anxiety, then he has learned that by running he can avoid this anxiety. Since this response reduces the anxiety, it reinforces his fear reaction pattern. Learning plays an important role in the development of neurotic reactions in the sense that one does not inherit a neurosis, but instead develops a neurosis, to cope with life situations.

Stress And Decompensation

Neurotic reactions may be precipitated by many types of stress situations. In general, the most frequent stress situations are as follows:

FAILURE TO LIVE UP TO ASPIRATIONS, WITH FEELINGS OF SELF-DEVALUATION AND INFERIORITY. Neurotics seem to suffer from a false sense of competition which makes them set unrealistic goals. Then when they fail, they develop feelings of inferiority, apprehensiveness and other faulty emotional attitudes which lead to the use of neurotic defensive measures to handle the threat on the self.

UNACCEPTABLE DESIRES AND "WEAK SPOTS." Conflicts centered around dangerous desires and childhood traumas have been emphasized by many theorists. The major origin of the neuroses is assumed to be the frustrations of instinctual desires and the resulting conflict between instinctual demands and learned social restraints. Also, childhood emotional experiences which lead to "weak spots" and faulty development may serve as an origin for later neurotic reactions.

IMPOSSIBLE CHOICES. The impossible choices or conflicts that are seemingly insoluble can be a precipitating psychological factor to neurotic behavior. For example the middle-aged schoolteacher who failed to marry due to her relationship with her mother now finds she is involved in a romantic affair with her married principal. On one hand she feels guilty and afraid of social exposure and loss of job, but on the other hand this may be her last possibility of romance. To continue the relationship is threatening but to give up her man was equally intolerable. So, under pressure she must decide. This may result in neurotic behavior such as tension, insomnia and somatic complaints. Conflicts may also be found deep within the mind and, due to the poorly integrated person, develop neurotic reactions. For example, a person may try to be what his mother expects, his father wants, what society expects, what he thinks he is and what he thinks he should be. This is confusing, hinders decision making and leads to indecision and various neurotic symptoms.

LACK OF MEANING AND HOPE. When a person lacks meaning and hope for himself, the outcome may be neurotic symptoms. This may be due to disturbances in interpersonal relationships, marital interactions, repeated failures or many other situations, all leaving this person with little to hold on to. This is threatening to the person and he must defend against the feelings or give in to them.

Immaturity And Guilt

This is the last psychological category of causes for neuroses that we will look at. Immaturity is viewed differently by many theorists. For example, O. H. Mowrer traced immaturity to the failure of a family to complete the socialization of the child. He felt that immature conscience development was based on underlearning, meaning the conscience was strong enough to leave the person with unresolved guilt and self-devaluation but not strong enough to control his immature egocentric behavior. As a result, he tries to repress his conscience to rid the guilt and this is the basis for the forming of neurotic symptoms. Sigmond Freud traced immaturity to a severe conscience (superego) which was in conflict with instinctual drives. The threat of id breakthrough makes the person develop defenses to protect the self. When defenses become exaggerated and interrupt personality integration, neurotic symptoms develop. The importance of immaturities and guilt in the lives of neurotics cannot be stressed enough as far as causes for neuroses.

The sociological factors for possible causes of neuroses is hard to evaluate since neurotic reactions are found among all people and among all economic groups. It is found that both the family setting and the broad social context in which the individual lives exert important influences on his adjustive behavior. As life conditions become more complex and insecure the incidence of neuroses increases.

Before continuing complete the following exercises.

1. The type of mental disorder in which all of the symptoms are centered around the direct or indirect coping of anxiety is called ______________________________.

2. Because the neurotic has very little ability to function under stress we would say he has a ________________ ________________ ________________.

3. Of the general personality characteristics of a neurotic which one would cause him to have poor interpersonal relationships? ______________________________

4. Fatigue, headaches, aches, pains, tension and indigestion are types of __________ symptoms experienced by neurotics.

5. Two of the three general theories that try to explain the psychological reasons for neurosis are

Confirm your answers on page 21. Correct those answers missed and review again. Continue with the next module.

SPECIFIC TYPES OF PSYCHONEUROTIC DISORDERS

Now we are ready to start our discussion on the specific types of psychoneurotic disorders.

Anxiety Reaction

This is the most common of the psychoneurotic disorders constituting about 30 to 40 percent of all neurotic disorders. It is characterized by chronic anxiety and apprehension which does not seem to stem from any particular threat. Because the anxiety is scattered and not related to one particular type of situation it is described as "free-floating anxiety." In other neurotic reactions the anxiety is handled by the development of defensive reactions to control the anxiety. In the anxiety reaction the neurotic is largely without these defenses and so the anxiety is free with nothing to be controlled by.

SYMPTOMS. The symptoms of an anxiety reaction are as follows:

1. It is first characterized by a constant state of tension, restlessness and uneasiness.

2. The person is irritable, has difficulty concentrating and suffers from insomnia.

3. He may be mildly nauseated or lose his appetite and consequently have a weight loss.

4. The person may experience heart palpitations, elevated blood pressure and an increased pulse rate for no apparent reason.

5. He may experience an acute panic attack that lasts for a few seconds to an hour or more. In these attacks, his heart pounds, he has difficulty breathing, his hands and lips tremble and he perspires excessively.

6. The patient has the feeling he is going to die or that something terrible is going to happen to him.

7. Usually the anxiety reaction lasts a few minutes and may vary in frequency from several times a day up to about once a month. If attacks last longer than a few minutes a sedative and reassurance will gradually quiet the patient.

Generally, anxiety neurotics are chronically apprehensive no matter how well things seem to be going. Not only do they have problems in making a decision but after they make one they worry excessively that it was the wrong decision. If they are not reviewing or regretting some past event in their life, they are anticipating all the difficulties that are going to rise in the future.

REASONS. Now that we have seen some of the symptoms of the anxiety reaction, let's look at some of the reasons for the reaction.

Many of us have moments in our lives when we feel much anxiety over some event that has happened. Maybe we lost a job, or had a marital problem that caused us to become very uneasy and anxious which is a normal reaction. However, in the neurotic reaction, the anxiety is considered to be pathological because it is chronic and is originated by a threatening situation which the average person could handle without too much difficulty.

In looking at the personality of the anxiety neurotic we see they tend to be introverted, sensitive, suspicious and usually have a high level of aspiration and strong guilt feelings because they failed to live up to their standards. Consequently they tend to be constantly ready for defensive action and overreact to a wide range of stress situations There are five kinds of situations that bring on anxiety attacks.

1. THREATS TO STATUS AND GOALS. Usually this type of neurotic has a history of feeling inadequate and inferior, and of reacting to the slightest threat of failure by a frantic redoubling of effort which only puts more strain on his abiliy to handle stress. Anything that is a threat to his staus or his goals raises his anxiety level and may precipitate an anxiety reaction.

2. THREATENING BREAKTHROUGH OF DANGEROUS DESIRES. Sometimes hostility or sexual desires may threaten to break through the individual's defenses into consciousness and result in behavior which would lead to serious self-devaluation and social implication.

3. ANXIETY-AROUSING DECISIONS. As you recall, the anxiety neurotics tend to have difficulty in making everyday decisions. This difficulty is greatly increased when they have to decide on a conflict that is really complicated such as giving up a moral value or losing security and status. This may cause much anxiety and a paralyzing indecision. Refer to the example of the school teacher on page 4 for a good example of an anxiety-arousing decision.

4. REACTIVATION OF A PRIOR TRAUMA. This is concerned with those stresses which reopen earlier personality wounds and hence are difficult to handle. Something that happened back in the patient's life that was stressful is relived or reactivated causing the anxiety to rise.

5. GUILT AND FEAR OF PUNISHMENT. An anxiety reaction may develop as an aftermath of behavior which arouses acute guilt and fear of punishment. This guilt and apprehension of punishment may be from an unhappy marriage and the life situation, or it could be guilt and fear from some repressed event in the patient's life. In any case, since the emotions of guilt and fear must be dealt with, they may serve as a predisposing and/or precipitating factor to a neurotic reaction.

We have looked at the symptoms of an anxiety reaction and some of the causes for the reaction. Presented below is a case of a lady who was diagnosed as an anxiety reaction. See if you can recognize the symptoms of her disorder.

> CASE: Mrs. A, a 30 year old housewife, sought psychiatric treatment because of the following symptoms: irritability, anxiousness, lower abdominal pain, numbness and tingling of her extremities, and marked fear related to her health.
>
> Although she had been a nervous person most of her life, her present symptoms had begun three months earlier and had occurred in "attacks." During a series of interviews, it was learned that the onset of her symptoms dated to the day when she was relieved of the responsibility of caring for her niece. The child had been left in her custody during the sister's hospitalization for delivery. Two factors in her history were of significance: she had been the oldest girl in a large family and had cared for the other siblings whenever her mother was hospitalized for deliveries and she had been married for ten years and had been unable to have children. Thus, the anxiety reaction was precipitated by her desires to have a family. Repeatedly she had been forced to "give up" children. The symptoms were signs of her conflict between the desire for children and her inability to have them. Her giving up the children three months earlier reactivated the conflict and precipitated the symptoms. Note that the symptoms were both somatic and psychic, were typical of anxiety, and came in attacks. The conflict was relatively superficial.

Conversion Reaction (Hysteria)

Conversion reaction is a neurotic defense in which symptoms of some physical illness appear without any underlying organic pathology. The unconscious anxiety and conflicts have been transformed into bodily symptoms. Because this mechanism of conversion seems to deal with anxiety more completely than any other, the patient's mood is often one of surprising cheerfulness and optimism. The presence of confidence and the absence of anxiety and depression in a patient with a severe physical disability (such as paralysis of the legs) may often be a significant pointer to the possibilities that the physical complaint has been brought about by the conversion mechanism.

SYMPTOMS. The symptoms of a conversion reaction are as follows:

1. Sensory symptoms - any one of the senses may be involved in a sensory conversion reaction. Some examples are as follows:

    a. blindness
    b. deafness
    c. loss of touch

2. Motor symptoms are concerned with the moving parts of the body and they can also be involved in a conversion reaction. Examples are:

   a. paralysis of a limb
   b. tremors or muscular shaking
   c. tics or muscular twitches
   d. speech disturbances, such as only being able to whisper or no voice at all

3. Visceral symptoms involving the organs of the body can also be involved in a conversion reaction. Examples are:

   a. headaches
   b. coughing spells
   c. nausea and vomiting
   d. anorexia nervosa - loss of appetite
   e. persistent hiccoughing or sneezing

Hysterical symptoms are capable of simulating almost every known disease. Therefore, it is important to distinguish between a patient's disorder that is the result of a hysterical reaction or the result of some real organic disturbance. Here are several criteria which help make this distinction:

1. Patients with hysterical disorders show little concern or anxiety over their disorders. They may have lost their sight, or hearing or cannot walk, but they do not seem to be worried about it. Whereas, a person who had an actual organic disorder would display some anxiety and fear that would be normally expected with blindness or paralysis of a leg.

2. The patient with an hysterical dysfunction may exhibit a selective nature. For example. he may be blind and yet he never bumps into anything. Or he may have a paralyzed muscle, but can use it for some activities.

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3. Under hypnosis or narcosis the symptoms of a person with a conversion disorder can be removed, shifted, or induced by the suggestion of a skilled therapist. This would not be possible for the patient with the actual organic disorder.

REASONS. Now let's look at some of the reasons for a conversion reaction.

In this disorder, the patient avoids or solves a problem by getting sick. This protects him from having to face the situation and at the same time bring him secondary gains by gaining extra sympathy and attention from people. Usually there is a chain of events in the forming of a conversion reaction.

- A desire to escape from some unpleasant situation
- A fleeting wish to be sick in order to avoid the situation
- Under additional or continued stress the appearance of the symptoms of some physical ailment. The original wish has been repressed and the symptoms have been substituted for it. Thus the patient sees no relation between his symptoms and the stress.

We have all used the excuse of getting sick to solve a problem or avoid something we did not want to do. The hysteric, however, unconsciously commits himself to this sort of reaction even though it disrupts his entire activity schedule. This is an emotionally immature, inadequate individual.

Sometimes a conversion reaction is used directly as a means of removing the individual from some unpleasant or dangerous situation. Like the man getting ready to leave for Viet Nam who develops hysterical amblyopia (visual weakness or dimness) or the singer whose throat could not stand the strain so he became sick in order to justify his failure.

A conversion may be used to regain or achieve some desired goal. For example, the boy who develops many stomach aches, getting the attention away from his new baby brother and back to him.

A hysterical reaction may also represent defenses against dangerous impulses. For example, the man whose wife left him for another and now he suffers from total paralysis of his legs. He actually had a strong wish to find his wife and destroy her.

We have looked at the symptoms and some of the dynamics involved in the conversion reaction. Here is a case of a man with a diagnosed conversion-reaction.

> CASE: A1C D, a 20 year old, was referred to the psychiatrist after being thoroughly examined by the Medical Officer. The airman had been returned from Vietnam with a paralytic condition of both arms.
>
> Of significance, through interviews, was revealed that he was a very religious individual. As such he had mixed emotions about his responsibility as a citizen and his basic philosophy. To fight and to kill was repulsive and sinful to him. Thus, he resolved the conflict by the disuse of his hands - the physical inability to handle the firearm.

Dissociative Reactions

A dissociative reaction is defined as a separation of a complex pattern of psychological processes, from the personality, which may then function independently of the rest of the personality. Dissociation reaction include amnesia, fugue, multiple personality and somnambulism. Let's look at each of these.

TYPES.

1. Amnesia and fugue. Amnesia is a pathological loss of memory, either partial or total, due to a variety of causes. The symptoms of a neurotic type of amnesia are as follows:

SYMPTOMS

a. Patient cannot remember name, age, his address, or his parents.

b. Patient is still able to write, talk, and seems quite oriented.

In this type of dissociation, forgetting is motivated because of some severe conflict or trauma that the person is seeking to escape from. The patient avoids an unpleasant situation by forgetting.

A fugue reaction is a type of amnesic state in which a patient actually wanders away from his present environment for weeks, days, or even years. During this time he has complete amnesia not knowing how he got where he is.

2. Multiple personality is a form of dissociative reaction in which an individual develops two or more personalities each of which is completely integrated of its own and which is relatively independent of the other personality. The symptoms for this are:

SYMPTOMS

a. Two or more complete systems of personality and behavior. Each personality usually very different from the other.

b. Usually an alternation from one personality to the other and one cannot remember in one what happened in the other.

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LARRY
TOM
MIKE
MARK

What we find with a multiple personality are deep-seated conflicts between impulses and beliefs. To solve the conflict these two aspects of a personality separate from each other and elaborate into another personality system.

Probably the most widely known case of a multiple personality disorder is that of a 25 year-old woman named Eve White. One of her personalities was Eve White, who was a good worker, good housekeeper, had notable literary tastes, devoted to her child, not spontaneous, and admired by others. Her other personality was Eve Black, who was attractive, likable, unthinking, quick, a rowdy wit, and enjoyed teasing Eve White. During psychotherapy with this woman, still another personality arose called Jane. Jane had a better attitude than Eve Black. After much therapy, a last personality arose, called Evelyn, who was like Jane, but more stable, and seemed to be a resolution of the entities of Eve Black and Eve White. Evelyn remarried and at last report had a happy marriage and family life.

3. Somnambulism (sleepwalking) is a type of dissociative reaction in which ideas not in consciousness are intense enough to cause abnormal behavior in a patient during sleep. The symptoms of this are as follows:

SYMPTOMS

a. Patient goes to sleep and sometime during the night carries out some act.

b. After finishing the act he returns to bed and has no recollection the next morning.

c. His eyes are partially or totally opened during the sleepwalking episode. Somnambulism may be a symbolic escape from a stressful situation for a person or it may itself discharge or inhibit tension. The patient attempts to carry out desires which were suppressed or repressed during consciousness. Sleepwalking is not very common and found most often during adolescence.

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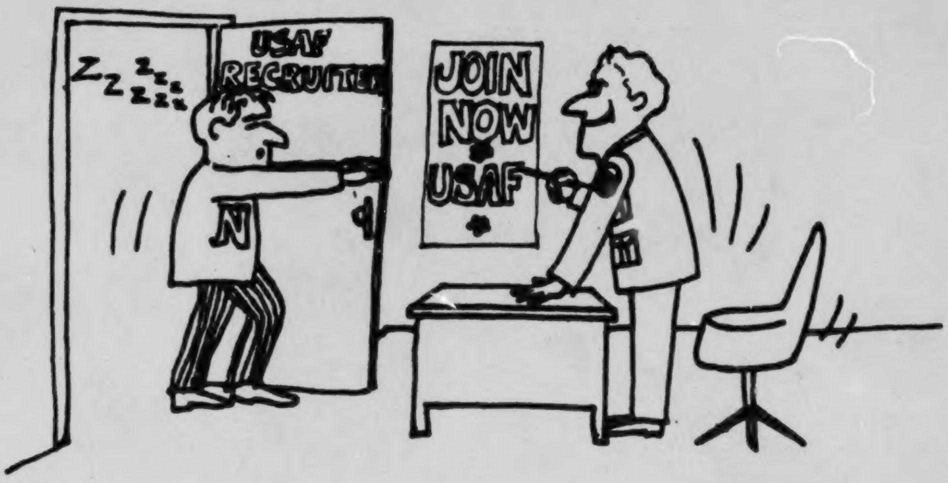
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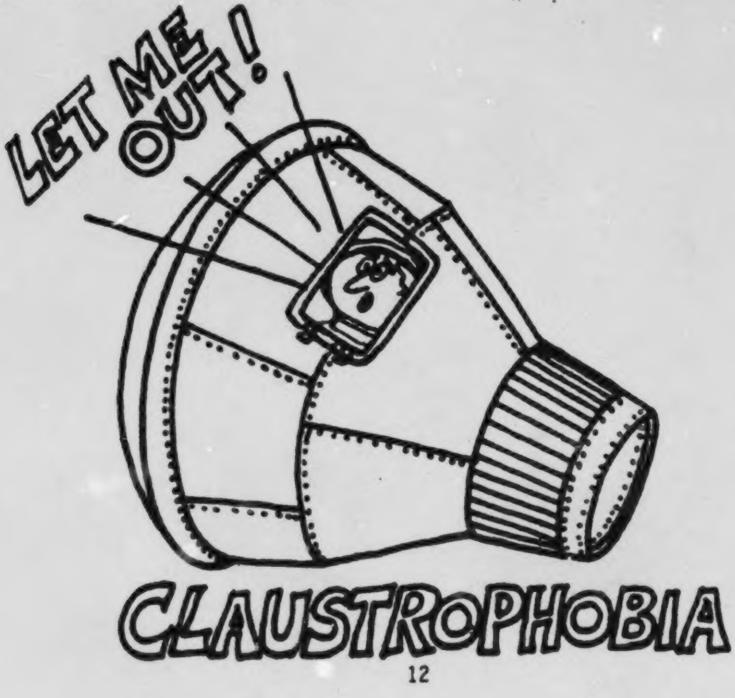
Phobic Reaction

This is a strong, persistant and irrational fear which is elicited by a specific stimulus or situation. The feared object or situation presents no actual danger to the patient or the patient magnified the danger all out of proportion to its actual seriousness. Symptoms of a phobic reaction are as follows:

SYMPTOMS

a. The phobia interferes with everyday activities of the patient.

b. Patients usually show other symptoms, such as headaches, stomach upsets, dizzy spells in addition to the phobia.


LET ME OUT!
CLAUSTROPHOBIA

Phobias are defensive reactions that help a person cope with dangers by either preventing their occurrence or carefully avoiding them. The use of the displacement to alleviate the anxiety from some stress situation to some other object or situation, is a common developmental pattern of a phobia. For example, a woman who experiences anxiety attacks associated with repressed sexual desires may develop a phobia of disease germs or syphilis - so that she now becomes highly anxious if a boy attempts to kiss her.

A phobia may represent a defensive reaction that will protect the person from situations in which his repressed aggressive or sexual impulses might become dangerous. Again, this anxiety is displaced and the object that the person is consciously afraid of is not the basic cause of his anxiety. For instance a husband may develop a phobia of sharp instruments because sometimes before he had persistent ideas of stabbing his wife.

A phobia may also develop out of a simple learned fear reaction. In other words, a person develops the phobia because his initial contact with the feared object was of intense fear and from this contact he learned to stay away. For example, a small child who had been attacked and scratched badly by a cat may have many vague and uneasy feelings around cats, even though this original attack has long been forgotten. A person can also learn to fear an obejct from examples set for him by phobic parents. For example, a mother who is deathly afraid of snakes may communicate this fear to her children.

Below is a 35 year old woman who was diagnosed as a phobic reaction.

CASE: Mrs. B., a 35 year old housewife, consulted a psychiatrist because she feared harming her children. She also had thoughts daily that some harm would come to her husband while he was away at work. After many hours of therapy it was learned that early in life she had felt rejected by her parents. She expressed desires to obtain from her husband and marriage that which she felt was denied by her parents. Thus, her own children were viewed as a threat to her relationship with her husband; she felt hostile toward them. She was also hostile toward her husband as she saw him as a rejecting parent. This hostility was repressed but expressed itself disguised as exaggerated fears. When the conflicts were brought to the conscious level, she was able to resolve them.

Before continuing, complete the following exercise:

6. The most common of the psychoneurotic disorders is called ____________________.

7. When anxiety is scattered and not related to one particular type of situation, it is described as ________________ ________________ anxiety.

8. The type of psychoneurosis in which the anxiety is connected on to organs or parts of the body is called a ____________________ ________________________.

9. Three ways to distinguish between a conversion reaction and an organic reaction are:

Conversion	Organic
1.	1.
2.	2.
3.	3.

10. The types of psychoneurosis characterized by the separation of psychological processes from the whole personality, which may then function independently of the rest of the personality is called a ____.

11. Three types of dissociative reactions are:

    a.

    b.

    c.

12. Type of psychoneurosis characterized by a strong, persistant, irrational fear which is elicited by a specific stimulus or situation is called a ____________________ ____________________.

13. What defense mechanism is used by a patient who has a phobia?

Confirm your answers on page 21. Correct those answers missed and review again.

The next type of psychoneurosis we are going to study are the obsessive-compulsive reactions.

Obsessive-Compulsive Reactions

This is a psychoneurosis characterized by persistent and often unwanted ideas (obsessions) and impulses to carry out some stereotyped irrational act (compulsion). Approximately 20 to 20 percent of all psychoneurotics are of this type. The symptoms are as follows:

SYMPTOMS

1. The person experiences recurring ideas that remain in the consciousness despite their irrationality. These ideas are called obsessions. At first these obsessions can easily be dismissed from the mind. But as they continue to recur, the more desperately the person tries to rid himself of them. This results in increased anxiety and an interference with his everyday behavior.

2. The other aspect of this disorder is the compulsion or a compelling feeling by a person to perform some act to relieve the obsession. Once a person performs the compulsion he usually feels satisfied, but if he tries to restrain himself from performing the compulsive act, he becomes overwhelmed with anxiety and tension.

There are several patterns that a person with an obsessive-compulsive disorder may follow. Some of the most common are:

PATTERNS

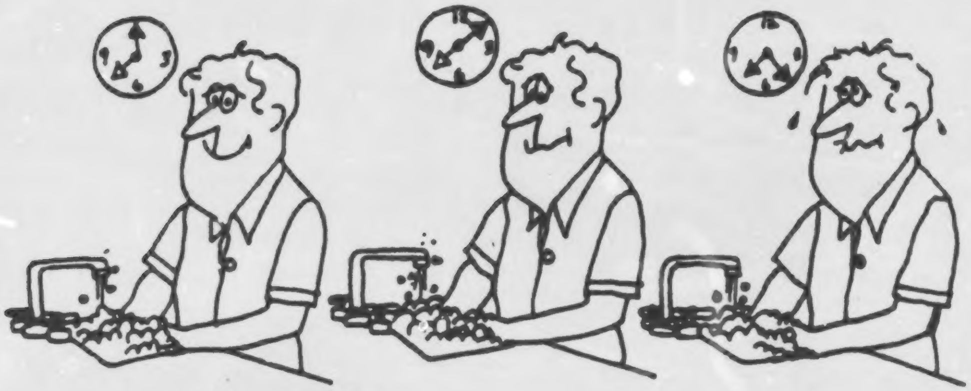
1. The obsessive-compulsive person may defend himself from anxiety by thinking or doing something each time a threatening thought or impulse enters his consciousness. For example, a person who is afraid of the dark is walking home late one night and keeps saying to himself that he is not afraid, thereby keeping his mind off the fact that he has a great fear of the dark. In this pattern one substitutes other thoughts or activities to keep unwanted obsession or compulsion from taking control.

2. Sometimes the obsessive-compulsive uses the defense of reaction formation in that he thinks or acts in ways which are directly contradictory to his dangerous thoughts or impulses. For example, a person who has lots of hostility against society may actually behave the exact opposite and become obsessed with acting or believing a certain way to protect the way he really feels or wants to act.

3. In some cases of obsessive-compulsive disorders, dangerous desires become conscious to the person and represent some wish fulfillment of the person that is unconscious. For example, a father has developed an obsessive thought of killing his small son. He is conscious of this dangerous desire, but unconscious of the fact that he did really want to kill his son because the boy had taken his wife's attention from him. He desires to return to the marital life when they had no children and he received more attention.

4. Obsessive-compulsive disorders may grow out of feelings of guilt and self-persecution for some unacceptable desire or forbidden act. These people usually experience much fear or possible punishment for their "bad" thought or behavior. For example, a woman who has stepped out on her husband feels very guilty and persecuted by this behavior. As a result of this fear that evolved from her unethical behavior she developed the obsession that she is a bad person and that anyone who comes in contact with her will turn bad. By this obsession she is protecting herself from the guilt and also from any reoccuring acts of being disloyal to her husband.

5. In some cases a person may attempt to rid himself of forbidden desires or dissolve the guilt by means of compulsive rituals. A good example of this is Lady Macbeth. She compulsively washed her hands after being a party to the murder of King Duncan. By washing her hands she was trying to cleanse herself of the guilt of her crime.



6. In many cases of obsessive-compulsive behavior, one finds an attempt by the patient to bring security and predictability into a world that is highly complex and dangerous. By developing a rigid pattern of order for himself he helps to prevent anything from going wrong. But, if the slightest detail gets out of order, then he feels threatened and anxious.

Below is the case of a 33 year old housewife who was diagnosed as an obsessive-compulsive psychoneurotic.

> **CASE**: Mrs. C, a 33 year old housewife, consulted a psychiatrist complaining of fear of germs and dirt, obsessions about religious ideas and about the number "3." These symptoms had begun about three months earlier, following the birth of her second child. She had experienced a similar episode five years previously immediately after the birth of the first child. That one lasted six months and cleared up after counselling sessions with her pastor.
>
> She was a smart person who was always orderly, methodical, conscientious and dependable. As a child she had been overly concerned with the usual compulsions that children have; compulsions such as counting the pickets in fences, avoiding the cracks in the sidewalks, etc. At age 10, however, she became obsessed with the idea that she would die on certain Tuesday in October. With her present episode, she developed a number of compulsions in response to her thoughts. For example, she washed her hands repeatedly and relaundered clothes. She never read automobile license plates and house numbers.
>
> After several weeks in the hospital, although still troubled to a degree she was able to carry on routine housework. The previous compulsive personality, the typical obsessions and compulsions, and her response to hospital treatment indicated a questionable health future.

Neurotic Depression

Another common type of psychoneuroses, encompassing 20-30 percent of psychoneurotic disorders, is neurotic depression. In this a person reacts to some stress situation with more than the usual amount of dejection and unhappiness. He often fails to return to a normal state after a reasonable period of time. The symptoms are as follows:

SYMPTOMS.

1. Patient's general appearance is one of dejection, disarrangement and sadness.
2. Patient has lowered self-confidence and a general loss of initiative.
3. Patient has problems concentrating and problems eating and sleeping.

Everyone has times when they feel blue or become depressed about certain situations that happen in their life. In the neurotic depressive reactions, one finds a person that becomes overwhelmed to life's unpleasant situations and overreacts to them.

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Asthenic Reaction

The last type of psychoneuroses we are going to study is the asthenic reaction. In this, the patient is characterized by much mental and physical fatigue along with a variety of aches and pains. It accounts for approximately 10 percent of the neurotic disorders and is found most often in frustrated housewives. The symptoms are as follows:

SYMPTOMS

1. Patient complains of mental and physical fatigue.

2. He has problems concentrating, a short attention span, and lacks vigor.

3. He spends a lot of time sleeping and when he is awake he is unrefreshed.

4. Shows a selective nature about his fatigue, meaning he has energy for things he enjoys but becomes fatigued with other activities he does not care for.

5. He usually complains about a mumber of somatic complaints, such as headaches, indigestion, dizzy spells and back problems.

A neurasthenic reaction is primarily due to prolonged frustration, discouragement and hopelessness that results in reduced motivation. There are likely to be emotional conflicts centered around hostility toward one's mate or the abandonment of cherished goals in many of these reactions. Because they do not understand why they are chronically fatigued they are forever searching for some bodily ailment that can account for the problem and relieve him of the responsibility of coping with a hopeless life situation. These individuals are immature, lack self-confidence and are overly dependent on others for security. They feel very inadequate in the face of a seemingly hopeless life situation. By developing many somatic psychological symptoms he escapes the necessity of dealing with his problems; he is just too tired and sick to worry about them.

We have finished our discussion on the specific types of psychoneurotic disorders. Presented on the next page is a table listing each one of the psychoneurotic disorders and the treatment that is most effective to handle this disorder.

TREATMENTS FOR PSYCHONEUROTIC DISORDERS

	Tranquilizers	Antidepressant Drugs	Psychotherapy	Hypnosis or Narcosis	ECT	Notes
Anxiety Reaction	X		X			Tranquilizers give immediate relief to anxiety
Conversion Reaction			X	X		
Dissociative Reaction			X	X		
Phobic Reaction			X			
Obsessive-Compulsive Reaction			X			
Neurotic Depressive Reaction		X	X		X	ECT used as a last resort
Asthenic Reaction			X			

Please keep in mind that tranquilizing drugs are administered in most all of the psychoneurotic reactions to help control the anxiety experienced with each. In most cases, however, the tranquilizers are not the most effective way of dealing with the disorder, but are important in that they keep the anxiety of a patient under control and make him accessible for psychotherapy.

The chief methods of treating the psychoneurotic patients are psychotherapy and chemotherapy. Psycnotherapy may range from supportive type to an intensive psychoanalysis before the patient will be helped.

The psychoneurotic patient is a challenging patient to work with. It requires patience and acceptance. By understanding each of the types of psychoneurotic disorders, it will make you as a psychiatric ward specialist more proficient in handling and understanding a neurotic's behavior.

Before continuing, answer the following questions.

14. What type of psychoneurosis are characterized by persistence of unwanted ideas and impulses to carry out some irrational act is called ____.

15. In the above disorder the persistent ideas are the ______________________ and the irrational acts are the ______________________________.

16. If a person reacts to some stress situation with more than the usual amount of dejection and unhappiness he is suffering from a disorder called ____.

17. Type of psychoneurosis characterized by chronic mental and physical fatigue is called ____.

18. One symptom a conversion reaction and asthenic reaction have in common is that

19. The two chief methods of treatment for the neurotic are:

a.

b.

Confirm your answers on page 21. Correct those answers missed and review again.

BASIC NUSING CARE MEASURES

You have now studied the different kinds of psychoneurotic disorders. Now lets look at some of the basic nusing care measures required for these types of patients.

Signs and Symptoms of the Psychoneurotic

1. They appear chronically tired.
2. They are very restless.
3, Most have difficulty in sleeping.
4. They experience frequent GI upsets.
5. They display tense facial expressions.
6. They are subject to anxiety attacks.

7. They are irritable.

8. They show impaired judgement and indecisiveness.

9. They are somewhat impulsive.

Patient's Problems and Needs

1. Patient is indecisive.

2. Patient makes excessive demands on personnel.

3. Patient tends to dominate conversation by talking about his physical symptoms.

4. Patient has a great need for recreation to direct his attention off his symptoms.

5. Patient needs reassurance.

6. Patient needs to be kept in the group so that he doesn't isolate himself.

Approaches To Meet The Above Needs.

1. You must realize this patient is truly sick and he is as uncomfortable as he says he is.

2. Avoid indicating you feel sorry for him or that you pity him.

3. The best approach for a neurotic in an anxiety attack is simply to stay with the patient.

4. On initial contact with the patient listen to his complete description of his complaints and history. After that, try to direct his conversation to the here and now problems.

5. Avoid showing contempt or excitement in regard to his symptoms.

6. Seek this patient out.

7. Recognize and reward the patient for positive accomplishments in his behavior.

You are now finished in your studies of the anxious patient. Prepare to take a quiz over the entire book.

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-7

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

THEORY OF SCHIZOPHRENIA

June 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

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Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

SW 3ABR91431-2-II-7
June 1975

THEORY OF SCHIZOPHRENIA

OBJECTIVES

Identify the different types of schizophrenia and the behavior patterns manifested by each type.

INTRODUCTION

The term schizophrenia is one which brings about different thoughts in all individuals. Because you will be working on wards where patients diagnosed as schizophrenics are located, a knowledge of this term and its meaning is needed. Knowledge of any subject tends to reduce the fear associated with it. Knowledge of schizophrenia will help to reduce the fear and anticipation you might have in working with a schizophrenic.

This supersedes SW 3ALR91431-II-7, November 1974.

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A BRIEF HISTORY CONCERNING SCHIZOPHRENIA

The term "schizophrenia" is a 20th Century word. Until the late 19th Century this disease was one of only a dozen or more undifferentiated, unclassified madnesses. The first step in the treatment of any disease is to define and classify it. The first steps in classification of this disease were done in the late 1800's and progress has been made only in the last 60 years.

Through the early 1800's all types of mental diseases were classified only according to meaningless behavior patterns. It was not until 1887, when Emil Kraeplin, a German psychiatrist, recognized the similarities of several conditions. He used the term "dementia praecox." The term means the deterioration of certain aspects of mental functioning during adolescence. He identified three subtypes: paranoid, catatonic and hebephrenic. These terms are still used today.

In 1911, a Swiss psychiatrist, Eugene Bleuler, published a book, Dementia Preacox or The Group of Schizophrenias. He included the same three types that Kreaplin used and added a fourth milder type "simple." Bleuler did not believe that this disease necessarily started during adolescence; he believed it could have its onset at any time in life. He changed the name to schizophrenia. The term schizophrenia comes from the Greek, and broken down is schizo/phrenia which means split/mind. The term does not mean split personality but has to do with a splitting of the psyche functions.

DEFINITION AND DESCRIPTION OF SCHIZOPHRENIA

Schizophrenia can be defined as a serious psychiatric disorder which tends to be chronic and generally leads to considerable disability. It involves disturbance in one or more of the basic psychological functions which are essential to comfortable and efficient living.

The person may have trouble perceiving himself or others due to hallucinations or delusions.

His thinking is often disorganized and illogical, and the responses to others is often inappropriate.

The person who is schizophrenic usually has trouble with goal directed behavior and inability to successfully complete a cause of action.

How do you recognize a Schizophrenic?

The Four "A"s

Bleuler believed that four primary symptoms were characteristic of schizophrenia. The 4 AS. are disturbances in associations and affect; ambivalence and autism. Actually these are found in normal people who are fatigued or anxious, but in these extreme forms they are found in schizophrenia, and thus used as diagnostic procedures.

A definition of how these 4 AS. can be seen in a Schizophrenic are as follows:

DISTURBANCE IN ASSOCIATION. This means the tendency of irrelevant features of the total concept to set off associations which interfere with logical, pointed thinking.

A normal person might associate the name with the mother of Christ, "Mary had a little lamb", or someone he knows named Mary. The Schizophrenic's thinking about the name Mary would be confused, vague and incorrect because of the jumble of irrelevant associations.

Example:
Dr: "What does the word Mary mean to you?"
Schizophrenic Response: "A flag, because Mary has four letters and the United States is divided into four sections; North, South, East and West."

DISTURBANCE IN AFFECT. Disturbed affect may be either a lack of emotional response, or a completely inconsistent response to a thought or action. The Schizophrenic may laugh at sad times and cry at happy times.

Example:
Dr: "I am sorry to say your father has just died."
Schizophrenic Response: Smiling - "That's too bad."

AMBIVALENCE. This is the virtually simultaneous occurance of opposing thoughts, emotions and feelings.

Example:
Dr: "How do you feel about your wife?"
Schizophrenic Response: "I don't know if I love her or hate her; everytime I think about her I get real confused."

AUTISM. Autism is a word coined by Bleuler to mean a tendency to withdraw from involvement with reality and become preoccupied with illogical, egocentric ideas, fantasies and distortion.

Example:
Dr: "When are you most comfortable?"
Schizophrenic Reaction: "I am happy when I can be by myself and dream about my magic world where I am the most handsome man in the world."

Secondary Symptoms

These symptoms are not necessarily present at any given moment in the illness and may never appear. They are not unique to schizophrenia and are seen in other conditions. They are very easy to recognize. The most recognizable are Hallucinations and Delusions.

Drug Reactions

Differentiation between schizophrenia and acute or chronic use of hallucinogens is important today. LSD, marijuana or amphetamines may produce symptoms similar to acute or chronic schizophrenia.

Kinds of Schizophrenia

Although schizophrenia is divided into various types there are actually few clear cut cases of one type of schizophrenia or another. For the most part, they seem to over lap. Following, are a few of the most common types of schizophrenia:

- Simple - tends to develop slowly and with a reduction of outside attachments and interests and growing apathy and indifference, which ultimately affects every level of a patient's functioning. It is progressive and gradually becomes worse.
- Hebephrenic - is characterized by shallow and inappropriate emotions, disorganized thinking, giggling, silly, regressive behavior and often a hypochondriac. They are often referred to as "grinning idiots."
- Catatonic - may be "excited" - with excessive, sometimes violent motor activity; or "withdrawn" with stupor, muteness, and waxy flexability. This type of schizophrenia is becoming more and more rare, but in the past some regressed back to vegetative conditions.

- Paranoid - is known by the presence of delusions of grandeur or persecution. There are often hallucinations, and the delusions often have great religious content. These patients may become hostile and aggressive. It is believed that these individuals project onto others characteristics which they can not accept in themselves.
- Latent - is a person who is clearly schizophrenic, but with no history of past psychotic schizophrenic episodes. Other names for this condition are incipient or borderline.
- Schizo-Affective - is a category where the persons have a mixture of schizophrenic symptoms and strong elation or depression. Where most schizophrenics have a flat or inappropriate affect, these persons affect is either elated or depressed.
- Childhood - is defined by its appearance before puberty. The symptoms may be autism, withdrawn behavior, identity confusions, or extreme immaturity and slow development.
- Undifferentiated - slow mixed symptoms of the above mentioned. The individual may be a silly hebephrenic who assumes catatonic poses and harbors a system of paranoid ideas.

WHAT MAKES A PERSON SCHIZOPHRENIC?

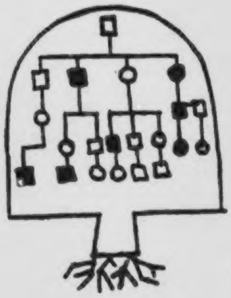
The answer to this question will not be answered in the next few paragraphs, but many indications as to what causes schizophrenia will be given.

As of now, no one has determined what the exact cause, if there is one, for schizophrenia.

Three areas that will be discussed are Genetic Causes, Environmental Causes, and Organic Causes.

Is the Cause Genetic?

To find out if schizophrenia "runs in families" through defective genes, researchers have been carrying out many studies for many years. The results have offered an indication that there is an inheritance factor in schizophrenia.



In the general population the chances of someone becoming schizophrenic is 1%. It rises to 2 or 3% for a person with a schizophrenic second degree relative such as an aunt or grandmother. For a child with a schizophrenic parent or sibling the chances are 10%, with two schizophrenic parents the chances 40%, and for an identical twin of a schizophrenic the chances are 50%.

These are merely statistics and do not tell us what is inherited or how. Much more research is needed to determine the exact relationship between the gene and schizophrenia.

Is the Cause Environmental?

An important environmental factor may be the individual's personal psychological development. This is formed, according to some theorists, by a childs earliest relationships with his parents; in particular, with his mother or mother substitute. Some theorists believe "it all begins in infancy", while others believe the entire childhood is to be considered.

According to many studies of the families of Schizophrenics, the mothers have been described as aggressive, rejecting, domineering, fussy, overprotective, lacking in understanding and overpossessive. The fathers were often passive, indifferent, threatening, or brutal.

In the typical family of a Schizophrenic, the members are unable to get together and approach a topic or a feeling straight on. One person may bring up a topic and the others, instead of responding to that subject, respond to something else. There is a genuine breakdown of communications present in the typical schizophrenic family.

Schizophrenia does occur most often in the lowest socioeconomic classes. It may be that more Schizophrenics are found among the poor and uneducated because, since the Schizophrenic is unable to deal with routine problems such as employment and education, he may move down the social scale even before his illness is recognized.

The same incident may drive a predisposed person to a schizophrenic breakdown while leaving another person sane. This is due to different people being able to handle stresses differently or how they learned to handle stresses.

Is the Cause Organic?

If schizophrenia can be found to have an organic cause, then perhaps it would be easy to cure. Many attempts have been made to show that mental illness does have organic causes.

Several substances have been found in the body fluids of Schizophrenics, only to be found later in the body fluids of normal people or in only a few other Schizophrenics.

Experiments with Mescaline or LSD have shown effects similar to those seen in schizophrenia; this has increased the hope that there is a substance which is causing the damage of schizophrenia.

Nobel Prize Winner, Linus Pauling, and others suggest that many mental illnesses are caused by deficiencies in essential nutrients. Some patients diagnosed as schizophrenia do actually have vitamin deficiencies, and when given quantities of B Vitamins or C Vitamins do actually improve, but such therapy does not seem to improve the condition of most Schizophrenics.

The work still goes on; is it organic, genetic or environment that causes schizophrenia. No one is quite sure, and schizophrenia is still one of the most serious and puzzling health problems present in our country.

TREATMENT OF A SCHIZOPHRENIC

Over the past 15 years the goals of the treatment of a schizophrenic patient have changed. Thanks to new advances in drug therapy the old back wards with their nude, incontinent, combative schizophrenic patients have been reduced.

The first big breakthrough came in 1952, when a drug called Chlorpromazine, a tranquilizer, was given to patients. The drugs controlled the behavior of the patients and helped them to be able to think more clearly. Today drugs are used often on psychiatric wards to control schizophrenic behavior. The most common types used are Thorazine, Stelazine, Haldol, Trilafon, Mellaril, and Navane.

Psychotherapy in the form of group therapy and individual one to one therapy is also being used to help the patient learn more about his behavior and why he is like he is. Groups involving the whole family of a Schizophrenic are extremely helpful in preventing a relapse by the patient when he returns home.

Other therapies such as Occupational Therapy, Recreational Therapy, and Work Therapy are being used to help orient the patient back into reality of real life.

Schizophrenia broken down means more than split/mind. When a patient is referred to as a Schizophrenic you should find out the specific type and thus be able to approach this patient with less anxiety and fear because of your knowledge of his illness.

You are now ready to take the Criterion Progress Check Subject Material.

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-8
June 1975

NURSING CARE AND APPROACHES - WITHDRAWAL

OBJECTIVE

Identify the correct nursing care and approaches for the withdrawn patient.

INTRODUCTION

One of the most challenging nursing care problems that you will face is the patient who has emphatically turned his back on interpersonal relationships and the society in which he lives. The withdrawn patient needs your help to get him back to a healthy social participation. Read this workbook and answer the questions at the end of this booklet.

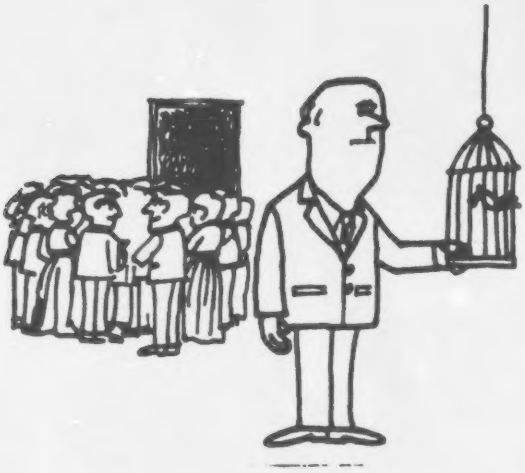
INFORMATION

WITHDRAWAL

Withdrawal is a defensive reaction consisting of retreat from threatening situations.

There are many types and degrees of withdrawal. The most fundamental form of withdrawal is the tendency to withdraw the hand or foot from a painful physical stimulus.

The human being develops psychological forms of withdrawal also. He may refuse to become involved. He may lower his level of participation, or simplify his life in order to avoid problems. He may react to defeat or failure by reducing his efforts for improvement or victory.



Withdrawal is an attempt to escape dangerous or frustrating situations, through retreat or surrender.

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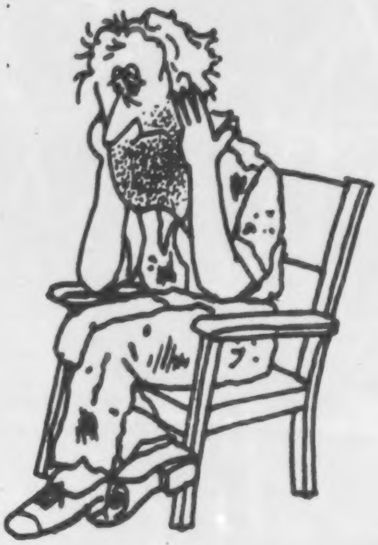
Withdrawal is usually carried out at a psychological level. The person may also fall prey to feelings of guilt for having given up. He may be overwhelmed with hostility towards others in an attempt to handle his frustration.

Withdrawal is often classified among the defense mechanisms, and as such, is considered a basically normal type of reaction. However, it may be exaggerated. One type of psychological reaction is withdrawal or "flight" into illness, the tendency to develop hypochondrical complaints. Another and more malignant type is the schizophrenics' tendency to withdraw from reality. This reaction generally begins with a loss of interest in people and events, accompanied by detachment, apathy, uncommunicativeness and a disinterest in school or work. If the tendency to withdraw is not arrested, it may progress to a full retreat from reality into an autistic world of fantasy, and in some cases, regression to infantile behavior, vegetative state, or even stupor or coma.



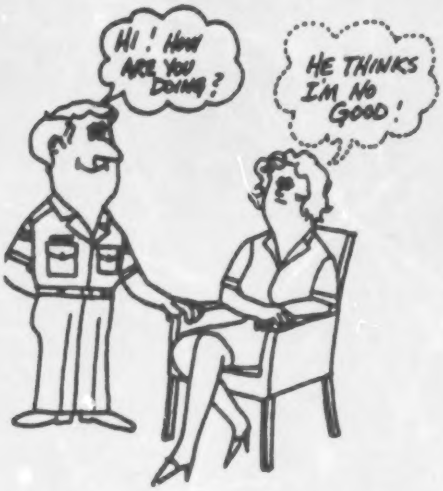
Withdrawal can lead to a lack of interest in oneself, people around him, and his job.

Simple Withdrawal

Sometimes, it is better to avoid or withdraw from a difficult situation that is exerting demands we cannot or prefer not to meet. Although many stress situations cannot be escaped, other situations can. For example, an unpleasant job or one with no future may offer so little reward that we look elsewhere, thereby withdrawing.

Schizophrenic Withdrawal

A Schizophrenic may break completely with reality and withdraw into a world of his own. He is preoccupied and inhibited by his own wishes, fears, and fantasies. His affect, speech, thinking and overt behavior are dominated by his inner life. The parts of the real world that filter through to him are misinterpreted and distorted. Another person's smile may be interpreted as a sneer, or a harsh comment as a sign of approval.


HI! HOW ARE YOU DOING?
HE THINKS I'M NO GOOD!

The severely withdrawn patient may misinterpret
the external reality around him.

NURSING CARE AND APPROACHES

The withdrawn patient may sit with an expressionless face, indicating neither pleasure nor pain, and seemly indifferent to what happens to him.

Nursing Care Plan

Patient's Problem	Plan of Care
1. The patient's thoughts and feelings may be confused and he does peculiar things, such as undressing at inappropriate times.	1. Recognize confusion and present plans or directions in a simple direct manner.
2. The patient's thoughts are often related to a dream-world, rather than reality.	2. Emphasize reality in every contact.
3. Patient feels insecure, shy, and isolated from people.	3. Use a warm, friendly and casual approach.
4. Delusions and hallucinations are present.	4. Be alert for evidences that the patient may act out on a hallucination or delusion with unpredictable behavior.
5. The patient's behavior and conversation are often in response to dreams instead of his immediate surroundings.	5. Try to anticipate changes; especially, resistance to some special activity recognizing that the response to this activity may be related to delusions.
6. The patient may draw away from friendly gestures or even resist them actively.	6. Direct simple questions and comments to him, repeated if necessary and expect a response.
7. The patient may not cooperate with ward regulations	7. Explain regulations, allowing him to comply. Be flexible.
8. Conversation may seem meaningless to you.	8. Overlook the conversation referring to day dreams and talk about the present.
9. The patient's personal hygiene and appearance may be neglected and elimination not regulated.	9. Encourage and supervise the patient in bathing, diet, and oral hygiene. Help him establish regular habits of elimination.
10. The patient may have physical symptoms such as swollen feet due to pacing.	10. Plan activities which do not involve pacing or walking.

Treatment and Activities

The treatments and activities may include individual or group psychotherapy, somatic therapy and chemo-therapy. Planned recreational, occupational and work therapy may also be prescribed. Seek out the patient's interests and skills and have him develop these.

Withdrawn patients need to be accepted, understood and encouraged. They need a consistent effort by staff members. Each new success in the interpersonal situation reduces the patient's guilt and will heighten his self-esteem.

Questions

Read each of the following questions and answer to the best of your ability.

1. Withdrawal can be a normal reaction?

   a. True

   b. False

2. Withdrawal is carried out only at a physical level?

   a. True

   b. False

3. Withdrawal can lead to lack of interest in ________________________________.

   a. friends

   b. reality

   c. jobs

   d. all of the above

4. One should never use withdrawal in his life?

   a. True

   b. False

5. Withdrawal can become excessive in schizophrenia?

   a. True

   b. False

6. Matching:

Problem	Plan of Care
1. Confusion	a. Be alert for unpredictable behavior. ______________.
2. Meaningless conversation	b. Give directions in simple manner ______________.
3. Neglected hygiene	c. Encourage, supervise, set example. ______________.
4. Delusions and hallucinations	d. Overlook conversation which refers to day dreams and talk about the present. ______________.

7. The most severe form of withdrawal involves a withdrawal from:

   a. A painful situation

   b. Others

   c. Reality

   d. Society

8. Which of the following is a good principle to follow when working with the withdrawn patient?

   a. Do not interfere with patient's actions unless he harms himself.

   b. Emphasize reality.

   c. Try different approaches daily until the patient accepts you.

   d. Keep the patient from interacting with other patients.

9. If you sit next to a withdrawn patient for 10-15 minutes and the patient says nothing, you should:

   a. Sit and wait, do not leave until the patient has spoken.

   b. Be patient, it may take days before he will accept you.

   c. Use small talk about any subject to be friendly with the patient.

   d. Leave, and before you go tell the patient if he needs you he can come find you.

10. The major problem with hallucinations in a withdrawn patient is that they may cause the patient to act with unpredictable behavior.

   a. True

   b. False

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-9

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

THE SUSPICIOUS PATIENT

April 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

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Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

SW 3ABR91431-2-II-9
April 1975

THE SUSPICIOUS PATIENT

OBJECTIVES

1. Identify the behavior patterns of the suspicious patient.

2. Describe appropriate nursing care and approaches for a suspicious patient.

INTRODUCTION

The suspicious patient is one of the most challenging problems that you will face. It is the task of offering a trusting relationship to a person who is hostile to all people he meets. Refer to the Defense Mechanism and Terminology Study Guide when reading this SW. Answer questions on the last page of this section.

INFORMATION

When we talk about the suspicious patient we are referring to several paranoid personalities. These paranoid personalities from a diagnostic standpoint can be broken down into several paranoid psychoses. The psychoses include paranoid state, paranoia, paranoid schizophrenia and involutional paranoid reaction. However, we find it difficult to say when expressions of a paranoid personality become symptoms of a paranoid psychosis. Therefore, we are concerned primarily with the nursing care of the suspicious patient and the dynamics of the paranoid personality rather than a specific diagnosis.

This supersedes 3ALR91431-II-9, November 1974

These characteristics are exaggerations of tendencies that we all see in ourselves. If people don't show appreciation when we think we should get it or someone does not show thanks or if we forget what we think have been injustices, we may become super sensitive, suspicious and maybe hostile.

PATTERNS OF BEHAVIOR DEMONSTRATED BY MENTAL HEALTH PATIENTS

To look at the patterns of behavior demonstrated by the suspicious patient, we must first look at his childhood. As a child, he was a rather unhappy person, lacking friends with whom he could share confidences, inclined to be mistrustful, stubborn, secretive and resentful of discipline. As he approached adulthood, he was rigid and unyielding in behavior, lacking a sense of humor, self confident, demanding, querulous, resentful, suspicious and made up stories inflating their worth. In some respects, he is often meticulous and precise and may be highly efficient but inclined to be jealous.

The suspicious patient is usually a sensitive person who misinterprets innocent comments of others as being personally directed. He may be hypersensitive to criticism and/or lack a sense of humor. For example, someone says he doesn't like cigarette smoking during a conversation. Thus, the patient is offended because he interprets the statement as a personal attack because he smokes.

The defense mechanism which is prominent in this patient is projection. He tends to blame others for his failures. He may say it is his supervisor's fault for not writing a good evaluation of his performance of duty when actually he did not do a good job. This supervisor may be included in his delusion that people are against him.

He has persistent feelings of persecution. Slights and indignities are imagined. The patient believes there is a plot and hostile agents are out to get him. He may hear voices (auditory hallucinations) of sexual perversions or believe his wife is running around on him. Because of these hostile thoughts and feelings contained in him, some paranoids must be looked upon as dangerous persons. As persecution feelings increase, the patient interprets other person's actions as being hostile. He hides his grievances toward these people and becomes more secretive about these suppressed feelings. The more these persecution feelings increase and the misinterpretations and misunderstandings are stored up and not clarified, the end result develops into a delusion of persecution.

In reaction to a conversation at one end of the room, the patient may come from the other side of the room to say "Are you guys talking about me?"

Ideas of grandiosity may appear in a patient after a persecutory phase. At other times grandiose ideas may have been present from the beginning. A patient may feel superior in one area or another and felt other persons were jealous of him. He may feel extraordinarily talented: He has made a remarkable invention that will change industry and make him rich; he has discovered a way to break the stock market; he is of royal blood or thinks he is the president.

The delusion of religious grandeur is common such as: he is God, disciple of Christ, the Virgin Mary or God is sending him messages (auditory hallucinations). He may even try to grow a beard and wear long hair in an attempt to imitate the supposed appearance of Christ.

To choose this type of grandiose delusion probably stems from the christian background in our society today.

His behavior is rigid and unyielding. He perceives his viewpoint as being the only one that is correct. He cannot admit an error because to do so would expose his inadequacy and vulnerability. This patient presents himself as having a "chip on his shoulder" attitude and often tries to be argumentative.

BASIC NURSING CARE MEASURES REQUIRED FOR PATIENTS WITH ABNORMAL BEHAVIOR PATTERNS

Signs and Symptoms

He can't see his environment realistically and his responses are often determined by his delusions of either persecution, grandiosity or both.

He does not trust other patients or staff members.

Often presents an attitude of superiority and may try running the ward his way.

Exploits all people around him and makes unsatisfiable demands of them. For example, he may ask you to take him off the ward when he is restricted to the ward and when you calmly say that he cannot leave because of his restricted level he will get angry with you.

He is so anxious about his problems he is unaware of the feelings of others.

Approaches and Treatments

The approach to suspicious patients is difficult as they present a hostile sometimes provocative air about them. The tendency you might have initially is to punch them in the nose. Obviously, you would get nowhere even though it may seem like a good idea.

The primary relationship for you in approaching the suspicious patient is to instill trust and understanding. To begin with, in any delusional state you would want the patient to accept reality. This can not be done by argument or making him abide by your expectations; this would only lead to antagonism.

For example, if the patient had the delusion he was some important person other than himself such as a disciple of God, a General in USAF, or an astronaut; the tendency for us is to play along with his story and fall into his delusional system. The reality is where we want to start. This reality is his name, Sgt Jones (who he is), the ward in the hospital (where he is). This basic reality of his name and ward are keys to ease him out of his delusional system. The trick here is to always call him by his real name and refer to the real environment but do not get into the trap of arguing with him. Accept the patient's rebuttals and abusive language as symptoms of his behavior rather than personal attacks.

Listen to the patient's delusional story without leading the patient to believe you accept it. You may offer an alternative point of view. For the persecutory delusions you may ask, "Now, for what reason would someone want to hurt you?" If you are aware of specific topics and exposure to troublesome areas that upset the suspicious patient it would be tactful to avoid these areas until the patient has worked well with reality thinking.

If possible, avoid demeaning his manliness and close physical contacts as he may feel threatened and misinterpret this as a homosexual gesture.

Inside the paranoid patient is anxious and fearful even though outwardly many are demanding persons. If you show an attitude of concern for his needs and try to understand, accept, and meet his demands he will to an extent become less demanding and more comfortable to work with. The better your relationship with the patient the greater will be his sense of security and self-esteem.

Consider his comments negative and positive as worthy of consideration, and praise him for the real ability and good accomplishments he does show. For example, when the patient is able to control his behavior when another patient becomes upset with him. Another example is a change in his behavior for a particular day or period of time when he is more friendly and less hostile or he has toned down his abusive language and recognizes that he is using abusive language and is trying to stop.

Occasionally, patients become so suspicious that they fear the food is poisoned and will not eat. Remedies for this problem may be to taste the food in his presence or allow him to go to the dining hall in a group where he can pick his own food and see everyone gets food from the same food serving pan. If his behavior is too disturbing to others, and he has to remain on the ward, then give him food that has not been opened such as milk in a carton or soda pop in a bottle or can and food in the original state such as hard boiled eggs and fruit that has not been peeled.

Many paranoid patients become irritable in the confines of a hospital and tend to focus on the staff the resentment he feels toward the hospital. The rules and procedures are constant sources of irritation. Many compromises may have to be considered in application of the rules with this patient. You should try to promote the patient's confidence in you and other staff members. Remember, you work as a team, and be consistent in your approach to these patients at all times.

TREATMENTS

At first this patient does not do well in a group setting because of his mistrustful nature. Games of competition would not be appropriate at this time because of his extreme jealousies. He does well alone in Occupational Therapy, on projects such as painting, leather crafts, and woodwork. Physical activities such as walking, swimming, and weight lifting help reduce tension. Before OT and RT are prescribed, take into consideration the patient's mental and physical capabilities. Is he heavily medicated? What are his interests? What is his degree of intelligence?

Close observation in the early stages of his illness is necessary because he is a potential suicidal risk.

This patient usually will be given medications as they often act out and respond to the delusional system they are in which is psychotic.

When giving medications to this patient watch closely so that he swallows the medication.

Many of them do not believe they are ill and will try to feign taking medications or they feel it may be another form of poison.

CONCLUSION

The most important need to establish with this patient is trust. These patients are the most difficult to work with as they are persistently hostile. If you can recognize that this behavior is a sign of their illness, it will be easier to care for this person.

Review Questions

Fill in the blanks or circle the correct answer.

1. The suspicious patient ______________________________ innocent comments of others as being personally directed and offensive to him.

2. The suspicious patient blames others for his failures because of a plot against him. The defense mechanism he uses here is ______________________.

3. The suspicious patient's responses are often determined by his ________ ____ rather than reality.

4. What is your approach to a patient who is talking about his delusional ideas?

5. Accept the patient's rebuttals and abusive language as ________________ of his behavior rather than ____.

6. In your approach to a suspicious patient, avoid specific topics _______ _________________________ ___________________________ the patient until the patient has ____.

7. Inside paranoid patients are ___________________ and __________________ even though outwardly they may be very demanding.

8. Give two ways that you may remedy the problem of the patient suspecting the food is poisoned.

9. Games of competition are good for the suspicious patient. (True or False).

10. The patient's adjustment to group therapy should be ____________________ as his ____.

WORKBOOK 3ABR91431-2-II-10

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

DEPRESSION

April 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

WB 3ALR91431-II-10
April 1975

DEPRESSION

OBJECTIVES

Describe the nursing care and approaches for the behavior patterns of a depressed patient.

INTRODUCTION

As a Psychiatric Ward Specialist, one of your most frequently encountered problems will be that of the depressed patients. These patients need special recognition and special attention. This is an audiovisual lesson designed to present you with the knowledge necessary to do or carry out your special duties with depressed patients.

INFORMATION

This instructional program is a combination audiovisual presentation and workbook. You will accomplish this instructional package in Room 1026 of the Learning Resources Center. You will complete the first portion of the audiovisual presentation and then complete Exercise "A." After confirmation of Exercise "A", complete the second and last part of the audiovisual presentation. Complete Exercise "B" and confirm it.

The audiovisual technician will direct you to a student carrel that has been prepared for this lesson. He will show you how to operate the audiovisual equipment. Once you start the program, follow the step-by-step directions. If you have trouble, push the stop button on the cassett unit, and get help from the AV technician. DO NOT TURN OFF THE SLIDE PROJECTOR.

This supersedes WB 3ALR91431-II-10, November 1974

EXERCISE "A"

Write answers in the space provided.

1. What are the two major types of depression?

2. Which depression leads to a break in reality?

3. Give three symptoms of a neurotic depressive reaction.

4. What are the three major types of psychotic depressive reactions?

5. What is characteristic of the manic depressive patient?

6. In which sex does manic-depressive reactions occur more often?

7. What are some symptoms of a patient with acute depression?

EXERCISE "B"

Before answering questions to this exercise, study the comparative charts that follow. This is information you are required to know but has not been included in the sound/slide presentation.

Comparison of Neurotic and Psychotic Depression

Psychotic Depression	Neurotic Depression
1. Depression not much affected if at all by pleasant environment	1. Depression may lift markedly in cheerful company.
2. Sleep disturbances invariably severe, usually awakens early.	2. Sleep disturbances may or may not be severe, difficulty getting to sleep.
3. Physical symptoms marked: amenorrhea, impotence, constipation, anorexia and weight loss.	3. Physical symptoms if present, do not cause change in body functions.
4. True retardation common	4. Never retarded in true sense
5. Speech slowed or patient mute	5. Usually talkative, anxious to discuss symptoms, complains
6. Delusions commonly present	6. Delusions never present
7. Patient tends to blame himself for his troubles.	7. Patient tends to blame others for his problems.
8. Patient may not realize he is ill.	8. Patient acknowledges illness.

Approaches Used to Meet the Needs of the Depressed Patient

Patient Problem and Need	Approaches to Meet Needs
1. Patient feels guilty.	1. Help patient to ventilate. Give menial tasks.
2. Patient might feel need for suicide.	2. Observe closely, especially when depression is lifting.
3. Patient neglects body hygiene.	3. Encourage showering, help when necessary.
4. Patient picks and pulls at hair.	4. Give tasks to occupy hands, OT, RT
5. Patient eats little or none.	5. Give attractive foods; feed if necessary.
6. Patient cannot sleep.	6. Focus away from problems at bedtime.
7. Patient sleeps too much.	7. Let sleep only during rest periods.
8. Patient sits for long periods.	8. Encourage exercise; direct away from problem.
9. Patient's not exercising enough.	9. Encourage moderate exercise, walking.

EXERCISE "B"

Write answers in the space provided.

1. What is the most severe degree of depression?

2. How is guilt associated with depression?

3. What change in the patient might indicate suicide is being considered?

4. List three ways in which neurotic depression differs from psychotic depression.

5. What one medication seems to control both manic and depressive behavior?

6. When is ECT used and on which type of depressed patient?

7. What are the four basic therapies used for depressed patients?

ANSWERS TO EXERCISE "A"

1. Neurotic, Psychotic.

2. Psychotic depression.

3. Sadness, inability to concentrate, loss of appetite, feeling of unworthiness, vague tension, anxiety.

4. Manic depressive reaction, chronic depressive reaction, involutional melancholia reactions.

5. The manic depressive patient has recurrent episodes of mood swings ranging from elation to depression.

6. Women.

7. Patients stand or sit in a dejected attitude, exhibit characteristics of being retarded, outlook is gloomy and morbid, loss of appetite, loss of weight, constipation.

ANSWERS TO EXERCISE "B"

1. The depressive stupor.

2. Patient feels that he is punishing himself for his sins.

3. Facial cast and voice are mournful; repeats such phrases as I don't want to live.

4. Cheerful company may lift depression; never retarded in true sense; usually talkative; patient tends to blame others for his problems; patient acknowledges illness.

5. Lithium carbonate.

6. When medication and chemotherapy will not help the patient. Psychotic depression.

7. Psychotherapy, chemotherapy, adjunct therapy, ECT.

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

SUICIDAL PATIENT

August 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

SW 3ABR91431-2-II-11
August 1975

SUICIDAL PATIENT

OBJECTIVE

State the signs and symptoms of a suicidal patient.

INTRODUCTION

As a Psychiatric Ward Specialist, you will be coming in direct contact with patients with suicidal tendencies. This Study Guide and Workbook will aid you in recognizing a possible suicidal person; and it will also show ways to treat the suicidal patient.

STUDY ASSIGNMENT

1. Read this Study Guide and Workbook.
2. Answer questions at the end of the SW.

INFORMATION

Suicide is defined as the act of taking one's own life. It is self murder. Suicide is an aggressive act, but it is an aggressive act turned inward as opposed to homicide which is aggression turned outward.

FACTS ABOUT SUICIDE

Ever since man's self-awareness and its corollary, the awareness of his mortality, have made him capable of taking his own life, suicide has been the object of dread as well as of curiosity far exceeding that directed toward any other manner of death.

Suicide is one of man's most common causes of death and it has had this honor since the dawn of history. Anything connected with death has had special importance in man's history; especially, a suicidal death. The dead were frightening and "unclean" (taboo). One may wonder how much of this primitive fear, rooted in "magical" thought and guilt feelings is still awakened whenever someone we know, no matter how slightly, commits suicide.

But there are other, more obvious reasons which make people feel uneasy, fearful or angry, when confronted with a suicide. The religious man believes that everyone's life belongs to God and resents the suicide's interference with the divine plan. The secularized man objects to suicide as being "against nature." Even those who recognize only chance believe that the contingency of birth ought to extend also to death and that therefore the individual should not interfere with "chance" in this respect, either. Moreover, it is easier for people to reconcile themselves to death when it comes as if decreed by destiny.

This supersedes SW 3ALR91431-II-11, November 1974

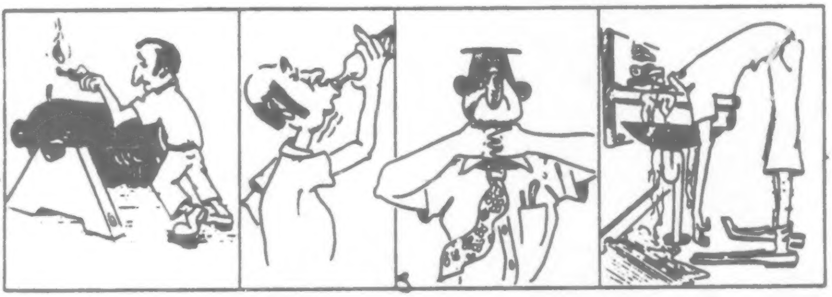
Suicide has been found to be among the top five leading causes of death in the United States among persons 44 years old or younger. In the age groups, 15 to 24, suicide was the third leading cause of death. If the deaths which are listed as "accidental," and which are apparently suicidal events, could have been listed, the known incidence of self-destruction would have been even higher.

Many studies have been done by doctors, psychologists, psychiatrists, and others seeking to find some key which will indicate who is a suicidal risk and who is not. The results have yielded a wealth of information concerning suicidal and potentially suicidal persons. The following are a few statistics concerning suicide:

More men commit suicide than women. In 1967, the World Health Organization recorded 15,187 male and 6,138 female suicide cases in the U.S. for that year. Men are about 3 times more successful than women in committing suicide. More women attempt to commit suicide than men, but the majority are not successful. It is estimated that there are between 10 and 20 attempted suicides for each completed one.

The 1967 World Almanac showed that the most popular forms of suicide are firearms and poisoning. The following chart shows the type and number of suicides for males and females during 1967, for the United States:

	FIREARMS	POISONING	STRANGULATION	OTHER
MEN	8,760	2,949	2,112	1,360
WOMEN	1,784	2,746	666	942



An interesting statistic concerning suicide and a person's marital status shows the divorced people have the highest rate of suicide and married persons have the lowest rate. The following chart shows how the marital status compares to the number of suicides per 100,000 persons:

MARITAL STATUS	PERCENTAGE OF TOTAL SUICIDES
Married	11.9
Single	20.9
Widowed	23.8
Divorced	39.9

Suicides occur more frequently in the white population of America than in the nonwhite. The ratio is about 2.5 to 1. The nonwhite population makes up about 11% of the total population yet it contains only 5% of the total number of suicides. The number of suicide attempts is percentage wise more predominant among nonwhites.

A person's occupation and suicide have been compared. The studies have shown that the lower the occupation level, the higher the suicide rate and the higher the occupation level, the lower the suicide rate. Certain professional people, however, do have a high percentage of suicides; the professional people who most often commit suicide are physicians; especially, psychiatrists. This seems to be due to the fact there is so much pressure on the doctors and they work with the mentally ill so much that they sometimes become depressed and kill themselves.

The preceding were simply a few facts about suicides; what is more important is the kind of person who commits suicide. The next section of this SW is concerned with the suicidal person.

THE SUICIDAL PERSONALITY

A study done in Philadelphia found the typical suicidal attempters to be young, nonwhite, healthy and female; and the suicide completers to be older, physically sick, white and male.

There are two criteria which should be used to describe someone who is truly suicidal. First, he must believe that death is the end of his existence. This is important because some people believe that death is the beginning of a person's existence. Second, the person has a serious intent to die.

Object-loss, the loss of a loved one or an object, is a definite source of suicidal potential. One theory states that when a child is young he is handled and becomes close to adults, and a "human bond" is formed. This bond is an inhibiting factor for violence toward others. When this bond is not made, does not develop properly, or is lost, the child develops with a weak link in his personality. There is usually ego impairment and a reduction of ego capacity. This means the self image is distorted, or the person is unable to perceive, think about, or act in relation to the self.

The suicidal personality generally has a lower threshold for tension. The suicidal personality may believe that suicide is a way to end the tension.

The suicidal personality is often unable to distinguish between "black and white." He may say, "Either, I pass this test or I kill myself." There are no shades of gray to this person; everything is either right or wrong.

The suicidal person also does not perceive death as simply going to sleep. He sees death as the end of his existence.

The suicidal person also seems to be very dependent upon someone or something; and when that person or thing is gone or taken away from him, the suicidal personality will often feel lost and dejected and feel like "giving up;" and the person might commit suicide.

Our society perceives anyone who asks for help as a sign of weakness. The person in trouble will sometimes "cry for help," but the cry sometimes is distorted and might be a suicidal attempt. Our society tends to teach coded, vague, hidden, and symbolic ways of conveying feelings. The healthier approach is to "tell it like it is," and thus confront the situation directly.

The personality is also influenced by environment. An example would be the range of differences in group opinions and taboos concerning suicide. Wars, over-population, and natural disasters are also environmental factors and may influence suicide. Changes in technology may influence suicidal behavior. A person might not be willing to put a gun to his head or swallow an overdose of pills, but he might be willing to drive a car off a highway at high speed. Changes in technology can also be used to deter suicide. For example, suicide by gas has been curtailed by the introduction of cooking and heating by electricity.

MOTIVES FOR SUICIDE

When we discuss the motives for suicide, the first and foremost factor which must be considered is a person's attitudes and beliefs about life and death. This has been discussed before and the major belief of a suicidal person is that death is the end of all life and existance.

Depression or melancholia is one of the first signs to look for in a suicidal person. These people are the most prone for suicide and they do give a warning. The following are known as the five D's of depression:

- Depression - marked by a morbid sadness or dejection.

- Debate - the way a person tries to decide how he could relieve his depression or guilt. He will consider life and possibly death. This period is marked by the person being preoccupied with his thoughts.

- Decision - the person has decided the only way to relieve the depression is to end his life. Because the depression will be ending soon, and because relief is in sight, the depressed person will now show a marked change in affect. The person will become much happier.

- Deed - the suicidal act; an overdose, hanging, etc.

- Death - the ultimate goal of the suicidal act.

Persons working with depressed persons should be alert to the change from depression to happiness, for this could mean the "death barrier" has been broken and the person has decided to commit suicide. Eight out of every ten suicides give definite warnings. Any suicide threat must be taken seriously. Suicide does not happen impulsively. Studies have shown that the suicidal person may give many clues to his intentions, often over a long period of time.

Some motives for suicide might be hallucinations, illusions, or delusions. These could result from delusions. These could result from drugs, alcohol, organic brain disorders, or psychotic mental illness. In recent years there has been considerable discussion regarding the relationship between LSD, Methedrine and suicide among young people. The investigation revealed that, while these drugs are a serious problem themselves, they have played little part in precipitating the self-destructive act of an adolescent. More common is accidental death in the course of taking the drugs. Drug taking or alcohol ingestion in excess is so obviously self-destructive, however, that one cannot overlook the suicidal mechanism in many instances.

A serious disease can also be a motive for suicide. The person in this case sees death as the way to avoid possible pain and suffering. One case was recorded of a young airman in Viet Nam who when told that he had a brain tumor, took an overdose of heroin and committed suicide.

During the involutional period, change of life, there is a slowing down of many of the body functions, expecially concerning sex. In the male there may be a feeling of impotency. Menopause may make the woman feel that she has no real reason to live any longer. During this period a person might commit suicide due to his loss of body functions.

Broken romances many times bring about suicides as do romances which are not broken. The thought of "dying for his one true love" has led many a starry-eyed young man to a quick meeting with fate. Shakespeare did much to idealize the beauty of teenage suicides, for the sake of love, with the suicides of Romeo and Juliet. In the military many suicides are caused by "Dear John or Jane" letters.

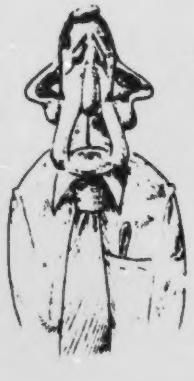
Suicides can also result from accidents. The clown or prankster will sometimes make an attempt at suicide simply to scare someone. Too often, their jokes result in death.

The above mentioned are only a few of the many motives for suicide. One should remember that each individual is different and all of the motives differ.

SIGNS AND SYMPTOMS

The suicidal person can look and act like anyone else. He can be happy or sad or angry. Most of the time, the situation we are in will dictate our feelings; so, a person can be happy and then be put into the proper situation, suicidal. For the most part, the suicidal person will show definite signs and symptoms, and you, the Psychiatric Ward Specialist, need to know, and be able to recognize these signs and symptoms of suicide.

- Unhappy expression - Commonly, this is called a depressed look. It can be a mild look of sadness or a deep melancholia.



- Preoccupation - The suicidal person is usually thinking deeply and seriously about one subject and this preoccupation is usually a feeling of guilt or unworthiness.

- Slow speech and action - Because of being constantly preoccupied and depressed the suicidal person might move slower and talk slower. This person is not motivated and sees no reason to move or speak at a normal pace.

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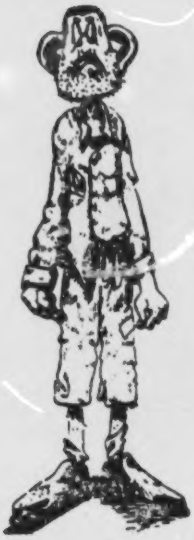
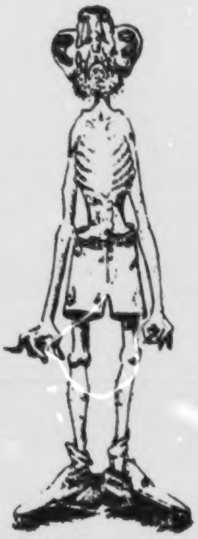
- Loss of interest in personal appearance - This usually is the easiest of all the signs and symptoms to recognize in a suicidal person. With no real reason to look nice, the appearance of a suicidal person will deteriorate.



- Loss of appetite - The suicidal person will usually have no reason or desire to eat, and weight loss will be obvious.



- Insomnia - Because of the preoccupation with guilt, the suicidal person will not be able to sleep at night, suicides are most common during the early morning hours, and if you work the night shift you should be aware of the relationship between insomnia and suicide.

PROBLEMS AND NEEDS

The suicidal person might have many problems and needs, but the most noteworthy is his wish to die. This wish stems, as was mentioned earlier, from any number of reasons. The major approach which the Psychiatric Ward Specialist should take is to lessen the need for suicide. This can be done by letting the patient ventilate his thoughts and feelings. The specialist can also help to establish new interests within the suicidal person.

The suicidal person will have the problem of personal hygiene. The specialist can use encouragement to help the person to be more aware of his personal hygiene and appearance. Sometimes, little things like complementing someone on his appearance, if it is good, will help him to become more interested in himself and in life. The Psychiatric Ward Specialist must offer the suicidal patient a nonthreatening and protecting environment. The specialist must also observe and record all information concerning the patient.

TREATMENTS PRESCRIBED BY THE DOCTOR

The treatments used by the doctor for a suicidal person will be similar to the treatments used on a depressed patient.

Psychotherapy is usually ordered by the doctor for the suicidal patients. One to one therapy is usually more effective for this person. Large groups often represent a threatening situation to the suicidal person. One to one relations with a specialist or nurse will help this patient establish a relationship with someone and possibly give him a reason to live.

OT, RT and IT are sometimes ordered for the suicidal patient. These therapies will give the patient a new interest in something or possibly revive an old interest.

Medications will sometimes be needed if the suicidal patient is also depressed or anxious. Most of the times the patient will receive an antidepressant medication like Elavil, Aventyl, Sinequan, and Tofranil.

As was mentioned earlier, depression is many times associated with suicide. Often the depression is so deep and the threat of suicide so great that ECT, Electroconvulsive therapy, will be administered in conjunction with other therapies; sometimes, ECT will be used after all other therapies have failed. ECT seems to effect the suicidal person in much the same way as it effects the depressed person. A complete understanding of how ECT works is not known, but it does seem to sometimes cause a lifting of spirits and a ceasing of the suicidal desire in some patients.

QUESTIONS

1. How is suicide defined, and how does it differ from homicide?

2. Who attempts the most suicides; men or women? Who suceeds most?

3. Psychiatrists have a very low suicide rate? TRUE or FALSE

4. What is meant by the statement "a suicidal personality can't distinguish between black and white?"

5. The suicidal person usually believes that death is the:

   a. Beginning of life.

   b. Complete end of life.

6. What are the 5 Ds of depression?

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

7. What are 4 signs and symptoms of suicide?

8. At what time of day do most suicides occur?

9. What type of medication is usually given to a suicidal patient?

10. The most important thing that a Psychiatric Ward Specialist can do to help a suicidal patient is to ____________________ the need for suicide.

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-12a

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

NURSING CARE AND APPROACHES - EXCITED PATIENT

August 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

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Department of Nursing
School of Health Care Sciences, USAF
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SW 3ABR91431-2-II-12a
August 1975

NURSING CARE AND APPROACHES - EXCITED PATIENT

OBJECTIVE

a. Describe the behavior patterns of the excited patient.

INTRODUCTION

The behavior patterns of the patients we will be describing in this lesson are extremely challenging and often difficult to work with. It requires much patient and understanding on the part of the staff to control and channel the seemingly endless amount of energy displayed by the excited patient. As a Psychiatric Ward Specialist, you will be directly in contract with the excited patients on your psychiatric unit. It is important for you to understand their behavior so that you can effectively work with this type of patient.

STUDENT ASSIGNMENT

Answer the questions at the end of this section.

INFORMATION

PREDISPOSING AND PRECIPITATING FACTORS

The disorder we are referring to when we talk of the excited patient is the manic part of manic-depressive psychosis. Manic-depression is a type of functional psychosis with the key characteristics being the changes in mood or affect of the patient, along with a thought and behavior disorder. Referring to the difference between neuroses and psychoses that were presented in the study guide on terminology, you will recall that a patient with a psychosis manifests a severe personality breakdown and loss of contact with reality. Therefore, a person who is suffering from a manic-depressive psychosis has one of the most severe forms of mental illness.

Manic-depression is defined as a severe mental disorder characterized by cyclic mood swings in emotion or mood. In the manic phase there is hyperexcitability, extreme elation, excessive motor activity, and a flight of ideas. We will not discuss the depressive phase, since it was already presented in the study guide/workbook on depression. Our main concern is with the excited or manic phase of this disorder. In its true form the disorder is an alteration between the two phases. However, some patients may demonstrate only the manic reactions, others only the depressive; still others show both types of reaction.

About 2 percent of all first admissions to mental hospitals are diagnosed as manic-depressive cases. The average age for this disorder is 44 and sex ratio is 4 to 3, with women having the higher ratio.

Biological Factors

The significance of heredity in the causation of manic-depressive reactions is relatively unclear, but most studies indicate that heredity is an important influential, predisposing factor. For example, one study found that 15-25 percent of the brothers, sisters, parents and children of manic-depressives were also manic-depressives. Current studies are now being directed toward the study of biochemical changes in brain functioning in manic-depressive reactions. But, the answers in this must also wait for further research.

This supersedes SW 3ALR91431-II-12a, July 1973

Psychological Factors

Many research findings have indicated that a manic-depressive comes from home backgrounds of competitiveness and envy. The parents in the home are usually very concerned about social approval and their prestige; thereby, formulating rigid standards of behavior for their children and severe punishment for any misbehavior. Evidence indicates that manic patients are usually outgoing, energetic, ambitious, successful and sociable prior to the onset of their illness. Manic-depressives appear to develop a high, conscious value on achievement and are deeply concerned with what society thinks of them.

The precipitation of a manic depression in most cases is stress-produced. Three of the most common precipitating stresses in manic-depressive reactions are:

1. Death of a loved one.

2. Failure in an important interpersonal relationship, such as a marital failure.

3. Severe disappointment or setback in a goal that meant a lot to the person.

In general, all of these stresses result in the loss or failure or giving up something of great value to the person.

As you recall, we said that a person can either be in an excited or manic state, depressed state, or alternate between the two. The state they develop is indicative of the way they are responding to excessive stress. In the manic pattern, instead of turning all his thoughts and activities inward like a schizophrenic, the manic tries to escape his difficulties by "running" into reality. He tries to deny his failures and inadequacies by portraying a person who is very competent. He becomes increasingly hyperactive trying to show his competence and takes on more activities than actually is feasible for a normal person. He feels he is stronger than any problem, and the world is his to operate according to his beliefs. In general, he becomes over active verbally and physically in order to avoid any threats of having to face an inadequacy or a failure. In the depressive patterns, instead of running from the stress and fighting its existence, the depressive tends to blame himself for his problems and develops feelings that he is hopeless and worthless. Refer to your study guide on Depression for more of the behavior patterns of a person in the depressive state. When a patient has both the manic and the depressive patterns the stress is handled as it was with each respective reaction. Changing from one mood to the other and consequently handling the stress in different ways causes much restlessness, excitement and fearfulness. Suicide is sometimes the only solution to such a situation, so this patient must be watched closely.

Sociological Factors

Manic-depressives are spread throughout the population. However, recent studies have shown that this psychosis is relatively more frequent among those of superior educational, occupational, and socio economic status. Manic-depression is much higher in the urban than rural areas and higher among divorced and separated individuals.

SYMPTOMS

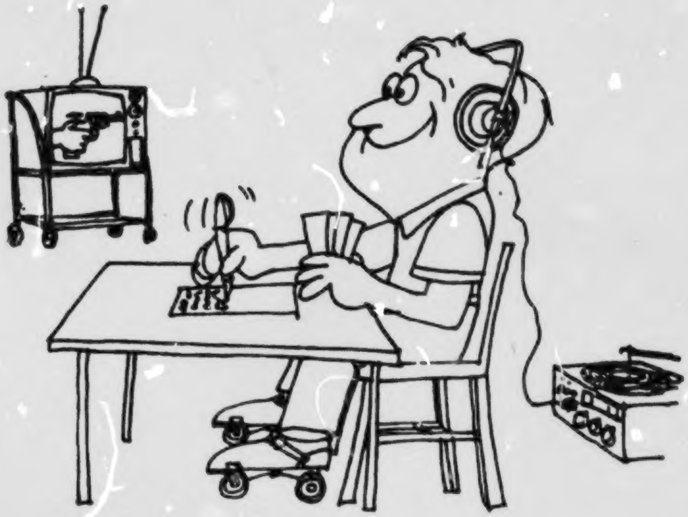
Now that you have studied some of the predisposing and precipitating factors in a manic-depressive reaction, turn your attention to some of the symptoms displayed by a patient with a manic reaction. In the manic reaction, you may find one of three degrees of elation and overactivity; they are as follows:

Hypomanic

This is a mild degree of mania, characterized by excitement, energetic behavior, restlessness, and high productivity. Some of the signs and symptoms of this are as follows:

1. Patient is very pleasant and states he has never felt better. He is very sure of himself in any type of activity and expresses his opinions quite freely.

2. His energy seems endless and he may go with little or no sleep. He engages himself in many activities such as talking, visiting, writing, telephoning and making numerous appointments.



3. At first the patient may seem very intelligent, sociable and energetic, but later he becomes domineering, attention-seeking, and demanding. He will not stand for any criticism and will become very defensive if someone tries to put him down.

4. This patient believes he makes no mistakes and easily rationalizes his behavior.

5. He displays poor judgment and usually lacks insight into his condition.

Acute mania

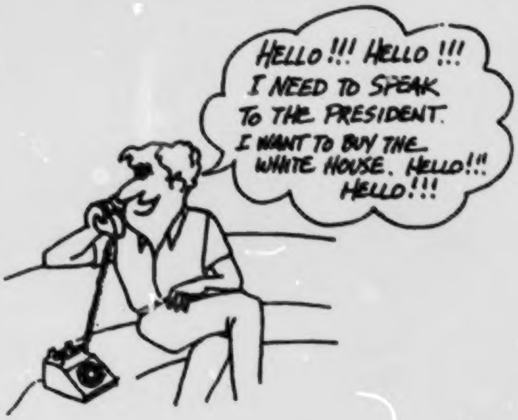
The symptoms of this mania are like the ones in hypomania only they are more pronounced.

1. The speech and activities of this mania are more pronounced and pressured. The patient is more boisterous, very dictatorial and often is ordering everyone around.

2. The patient's mood may change quickly from gaiety to anger. During this time he may start pacing, singing, breaking objects, assault nurses, use obscene language, make sexual advances or become mean to other patients.

3. This patient has a wild flight of ideas, and his speech may be confused or incoherent.

4. The patient may experience some delusions or hallucinations. Usually, the delusions they experience are delusions of grandeur. When this happens they may believe they are some very important person or have a great deal of money. They may start trying to negotiate big plans or big deals.


HELLO!!! HELLO!!! I NEED TO SPEAK TO THE PRESIDENT. I WANT TO BUY THE WHITE HOUSE. HELLO!!! HELLO!!!

5. The acute mania is irritable with an elated mood. They experience many irrational ideas and extreme psychomotor over-activity.

Delirious mania

This is the most severe type of manic reaction in which the patient is very confused, wild, excited and violent.

1. Patient is incoherent, and very disoriented.

2. Patient usually experiences delusions and hallucinations.

3. The patient is extremely overactive, with violent, destructive behavior. He spends his time pacing, screaming, shouting or singing.

I WANT TO BE FREE!

4. The patient's behavior is very obscene and his personal hygiene is deteriorated.

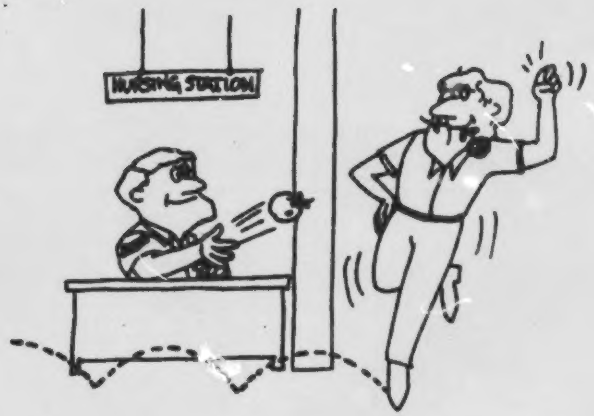
5. Patient may lose weight rapidly and may become utterly fatigued.

In general, in all the manic degrees, you find a speeding up in the patient's thinking and motor activities. They are loud, boisterous with little insight. They are very easily distracted and have a very low attention span.

NURSING CARE APPROACHES

Now that you have looked at the signs and symptoms of a manic patient, you can readily see the challenge they present to the staff. The staff must be alert, tactful and resourceful when trying to deal with the manic patient. Presented below are some of the problems and needs of the manic, and some approaches or solutions employed by the staff to meet the needs or solve the problems. At all times that staff needs to be firm and consistent with this patient. They should never use force on this patient unless it is absolutely necessary. Force just increases his anxiety and will not help.

Problem or Need	Approach or Solution
1. Patient may refuse food and drink. He may be too busy to bother with food.	1. Staff should encourage food intake and may even spoon-feed the patient. If patient is too active to eat, give him food that he can carry with him such as fruit or sandwiches. Staff should observe for a weight loss.



2. Patient pays little attention to elimination and other physical health needs.	2. Remind patient of these needs. You may have to assist him in their execution such as brush his teeth.
3. Patient displays very little insight and may use poor judgment.	3. Reality testing is a good approach to this problem. Letting the patient know the reality of a situation may prevent further confusion. Due to his poor judgment, the staff has to protect the patient from situations that may harm him. For example, a manic may want to take all his money out of the bank and distribute it to the rest of the patients.
4. He may become very demanding of the staff and try to take over the ward by setting his own rules or by ordering the other patients around.	4. Staff should maintain a calm manner with the patient. They should be firm with the patient, but try not to use force. By getting excited with this patient or using force, you increase anxiety. Explain to the other patients about the manic's behavior so they will understand some of his behavior.

5. Of course the greatest problem with this patient is how to handle his excess energy.	5. Try to divert this patient's activities into constructive channels. They may have him clean a room or some other household duty. They could take him outdoors for some type of mild non-competitive activity such as a walk or tossing a ball. Noncompetitive forms of OT and RT are helpful to use. Competition makes the manic physically try to out do himself.
6. The patient may resort to destructive behavior.	6. The staff has to control the patient even if it means some form of restraint. If they do restrain him, they should check him frequently and spend some time with him.
7. Manic patient may not find time for sleep.	7. Staff should use much reassurance at this time and administer a sedative if needed.

Presented above are just a few of the problems that may arise with a manic patient. When you are working with a manic it is important to use a team approach so you can successfully recognize and help meet the problems and needs of the manic.

We have looked at the dynamics and the symptoms of the manic reaction. Now the question arises, "How can they be helped?"

The immediate aims of treatment for the manic is to reduce his overactivity. To help accomplish this, tranquilizers have proven effective. In some cases where the drugs do not seem to be helping, electroshock therapy or even the prolonged use of narcosis is administered. A very important part of the treatment for this overactivity is the directing of this energy into constructive channels as was presented above.

Once you have controlled this overactivity and the patient has calmed down, then psychotherapy is used to help the patient become more stabilized in his ways of improvement and to help him achieve a more satisfactory long-range adjustment.

As was stated, the manic patient is a challenge to work with and requires a lot of patience on the part of the staff. By understanding the motives behind his behavior you will be better able to keep your composure and form a therapeutic staff-patient relationship.

QUESTIONS

1. Manic-depression is considered a : Neurosis / Psychosis

2. Manic-depression is a: functional / organic ilness.

3. Research shows that a manic-depressive comes from homes where:

   a. There are rigid standards of behavior.

   b. The family prestige is important.

   c. The children are allowed to do as they please.

   d. The parents care less of what society thinks of them.

4. The manic-depressive can either be in the manic stage, depressed stage or changing from one stage to another.

TRUE / FALSE

5. The mildest degree of mania is called: Hypomanic / Acute mania

6. The type of mania very similar to hypomania, except the symptoms are more pronounced is called: Acute mania / Delirious mania

7. The greatest problem with an excited patient is what to do with his excess energy.

TRUE / FALSE

8. Excited patients always show good judgment. TRUE / FALSE

9. It is good for the excited patient if the staff treats him very inconsistently so as to show him this is how he behaves.

TRUE / FALSE

10. Noncompetitive activities are the best for the excited patient.

TRUE / FALSE

11. Psychotherapy is almost impossible with the excited patient until his over-activity has been controlled.

Turn your workbook in to your instructor for review and correction.

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

NURSING CARE AND APPROACHES FOR THE PATIENT WHO ACTS OUT

June 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

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Department of Nursing
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SW 3ABR91431-2-II-12b
June 1975

NURSING CARE AND APPROACHES FOR THE PATIENT WHO ACTS OUT

OBJECTIVE

State the behavior patterns of the patient who acts out his anxiety.

INTRODUCTION

More than half of the patients admitted to military mental health units are diagnosed as character and behavior disorders. These patients present challenging situations, both nursing and medical, because they do not appear mentally ill; yet they are quite manipulative and can upset the ward routine. Managing these patients and devising effective nursing care plans for them is very difficult. This book is designed for them so they do not upset the ward routine and disrupt the sicker patients.

INFORMATION

OUTLINE OF CHARACTER AND BEHAVIOR DISORDERS

1. Behavior Disorders
    a. Combat exhaustion
    b. Acute situational maladjustment
    c. Chronic situational maladjustment
2. Character Disorders
    a. Special symptom reactions
        (1) Stuttering
        (2) Nail Biting
        (3) Tics
        (4) Enuresis
    b. Pathological personalities
        (1) Schizoid
        (2) Paranoid
        (3) Cyclothymic
        (4) Inadequate
    c. Psychopathic personalities
        (1) Antisocial

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This supersedes SW 3ALR91431-II-12b, November 1974

- (2) Dyssocial
- (3) Sexual deviants
    - (a) Homosexuality
    - (b) Transvestism
    - (c) Pedophilia
    - (d) Voyeurism
    - (e) Exhibitionism
    - (f) Fetishism
    - (g) Sadism
    - (h) Masochism
- (4) Addiction
    - (a) Drugs
    - (b) Alcohol

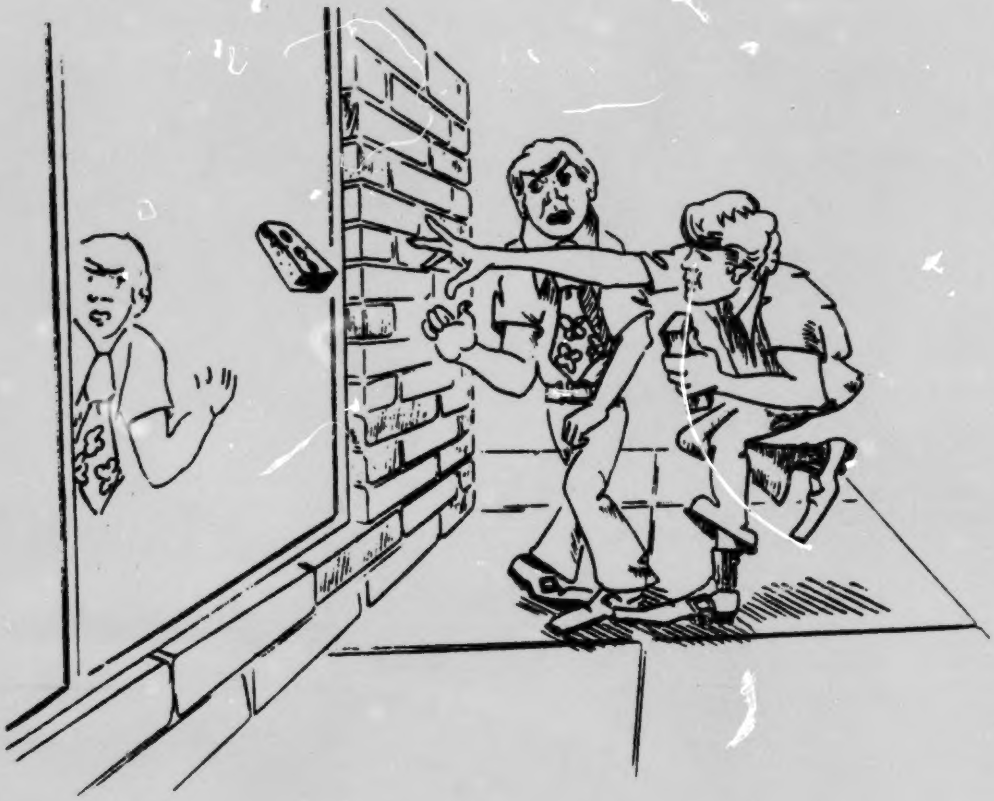
d. Immature personalities

- (1) Passive aggressiveness
- (2) Emotional instability
- (3) Passive dependency
- (4) Compulsive personality

Most individuals are able to relieve tensions and handle adjustment problems by using socially acceptable methods such as the various defense mechanisms. Individuals with character disorders and behavior disorders tend to display behavior which is overt and maladjusted.

Character disorders and behavior disorders differ from each other in many ways, but both are similar in one important way. Individuals who suffer from character disorders and behavior disorders both "act out" their inner feelings.

An example of "acting out" is: A young man is angry with a friend; he is standing next to a window. He has the impulse to break the window; he breaks the window and thus displays one of the major symptoms of a character and behavior disorder. He "acts out" his aggression instead of trying to channel it into something socially acceptable, like going to the gym and working out.



We will divide the character and behavior disorders into character disorders and behavior disorders. The first to be discussed will be the behavior disorders.

PATTERNS OF BEHAVIOR DEMONSTRATED BY MENTAL PATIENTS

Behavior Disorders

Many psychiatric symptoms develop when the "going gets tough." In most cases of neurotic and psychotic behavior we are dealing with long term trends of maladjustment which are central to the whole personality of the person. There are, however, certain situations such as a terrifying accident, assault or rape, and combat situations which can cause a usually stable, normal individual to fall apart.

The symptoms sometimes resemble a neurotic or psychotic reaction yet they clear up in a short time with only mild therapy. Most of these disorders are transient and clear up easily.

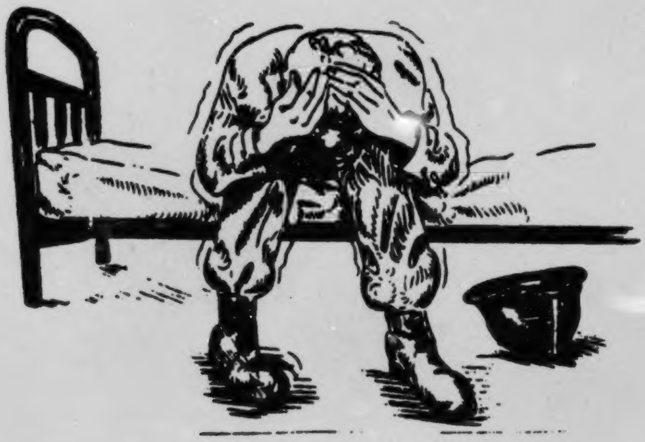
The definition we will use of a behavior disorder, then, is: temporary or transient decompensation and/or acute symptom response to an overwhelming situation in a basically stable personality.

COMBAT EXHAUSTION. During World War I, reactions to combat situations were called "shell shock." The Army attributed the behavior of people suffering from "shell shock" to an organic condition produced by minute hemorrhages of the brain. Studies later showed that only a very small percentage of such cases represented physical injury from concussion of exploding shells or bombs. Most of these men were suffering instead from the general combat situations with their physical fatigue, the ever-present threat of death or mutilation, and severe psychological shocks.

The use of the term combat exhaustion is not really the best for it implies that the condition is caused by purely physical problems. Most of the conditions of combat exhaustion are brought about by psychological problems.

Estimates have shown that about 10 percent of the men in combat during World War II suffered from combat exhaustion. The Army accepted nearly 10,000,000 draftees and volunteers during World War II and approximately 1,363,000 were given medical discharges, nearly 530,000 of these were for neuropsychiatric disorders.

The typical picture of combat exhaustion displayed symptoms of dejection, weariness, hypersensitivity, sleep disturbances and tremors. These symptoms were especially true of ground troops. The Air Force personnel displayed symptoms of anxiety, dejection, depression, phobias, and irritability. Regression and flight (AWOL) were also demonstrated. Sometimes in severe cases, stupor and amnesia result from a repression of traumatic experiences.



Some of the predisposing factors of combat exhaustion are:

1. Not knowing what to do in a strange situation. (No training can fully prepare the soldier for all the conditions of battle.)

2. Immobilization caused by being "pinned down" by the enemy causes anxiety to mount sometimes and often becomes overwhelming.

3. Often men feel guilty because of the necessity of killing enemy soldiers. This guilt will make some individuals wish to be punished and can be a major predisposing factor in combat reactions.

4. Often due to prolonged combat a soldier will feel his "luck has run out."

5. This is often a conflict between a soldier's desire to run away or give up and his devotion to duty.

6. Personal immaturity, often stemming from maternal overprotection, has been cited as making the individual more vulnerable to combat stress.

Most of the time the treatment for combat exhaustion is very simply removing the patient from the combat situation and giving the patient mild supportive psychotherapy, warm food, and sedation to help the soldier gain needed sleep.

NOTES:

ACUTE SITUATIONAL MALADJUSTMENT. People who are exposed to plane crashes, automobile accidents, explosions, fires, earthquakes, tornadoes, sexual assaults, or other terrifying experiences frequently show "shock" reactions (transient personality decomposition). Other events such as the sudden loss of loved ones, social disgrace, or severe financial losses may prove extremely traumatic. All of the above situations might precipitate maladjusted behavior.

As in combat cases, some people who undergo terrifying accidents reveal a somewhat typical post-traumatic syndrome which may last for days, weeks, or months. The following are examples of the symptoms often displayed by individuals suffering from situational disorders. (a) anxiety varying from episodes of mild apprehension to panic; (b) chronic muscular tension with tremors, restlessness, insomnia, and inability to relax; (c) repetitive nightmares reproducing the traumatic incident directly or symbolically; (d) irritability, often accompanied by a startled reaction; (e) withdrawal and avoidance of any experience that might increase excitation.

One major dynamic of acute situational maladjustment is basically the fact that the world which has seemed relatively secure and safe suddenly becomes terrifying, and one's adjustive abilities have become completely inadequate. In the face of a threat, the individual is overwhelmed by intense anxiety and is unable to function in an efficient manner.

The treatment of these disorders differs very little from that of combat exhaustion except that there is no need to prepare the individual to face the traumatic situation again. Proper rest and reassuring psychotherapy usually lead to the removal of the symptoms. The most important treatment is psychotherapy. Psychotherapy prevents conditioned fears from building up again within an individual.

CHRONIC SITUATIONAL MALADJUSTMENT. In addition to the transient reactions to acute stress seen in combat exhaustion and acute situational maladjustment, transient reactions may also build up when the individual continues for an extended time in a situation where he feels threatened, seriously dissatisfied, or inadequate. These reactions might be caused by the regimentation of Army life, an unhappy marriage, or childhood personality disorders resulting from a bad family environment.

Reactions of Prisoners of War and of individuals in concentration camps are often causes of chronic situational maladjustment. These chronic reactions are not the result of sudden traumatic experiences, but are the result of many days, months, or years of constant pressure.

One example is the child who has difficulty adjusting in school. This child is hard to treat because he cannot be allowed to remain home from school, yet school might cause such a traumatic reaction that the child feels constantly threatened. Psychotherapy, especially group therapy, would be used in this instance because it would help the child to react properly in a group situation, such as school offers.

Combat exhaustion, acute situational maladjustment, and chronic situational maladjustment are all examples of behavior disorders. They all result from a falling apart under stress and are not the result of faulty development. The next section of this study guide and workbook will be concerned with individuals suffering from a weak link in their personality which has resulted in a character disorder.

Character Disorders

This portion of the SW is devoted to the character or personality disorders. These disorders are a result of the faulty development of an individual rather than a falling apart under stress. Occasionally head injury, epilepsy, or alcoholic intoxication plays a major role in this type of behavior, but in most cases there is no apparent organic cause.

The character disorders will be classified under four subheadings:

a. special symptom reactions such as stuttering and nail biting;

b. pathological personalities;

c. psychopathic personalities; and

d. immature personalities.

Each of these will be discussed on the following pages.

All of the above mentioned disorders have some characteristics in common. The most important characteristic is that they "act out" all of their frustration instead of channeling them into socially acceptable areas.

SPECIAL SYMPTOM REACTIONS. This category is used where a specific single symptom is outstanding. The specific symptoms are sometimes the result of a character disorder or the character disorder itself. The symptoms which shall be discussed here are stuttering, nail biting, tics, and enuresis.

Stuttering. Stuttering involves a spasmodic blocking of certain speech sounds. Typically there is repetition of the initial syllable of some important word or phrase, as in "The b-b-b-boy let the d-d-d-dog out." Speech sounds which are the hardest to articulate are especially troublesome, such as b, d, s, and t.

Often when a person begins to stutter he will exhibit jerking of the body and head, shaking of the whole body and facial grimaces. After the initial struggle to speak, the person will not show any of these body movements until the next stuttering episode.

NOTES:

The stuttering varies from one situation to another. For example, most stutterers can speak normally when they are alone, whispering or singing, or with people younger than themselves or with someone whom they consider to be their inferior. The stuttering will increase when the person feels inferior, embarrassed, or self-conscious.

There have been many explanations offered to show what causes stuttering; a few will be presented here. (1) Hereditary Theory. There is a tendency for stuttering to be found in successive generations of the same family. One study showed that children who stuttered had parents, mostly fathers, who also stuttered. Most of the parents who stuttered seemed to overreact to their children's normal disfluent early speech. This often caused the children to become very self-conscious and tense about their speech and could lead to actual stuttering. (2) Neurological Theory. Theories of stuttering have frequently emphasized brain damage resulting from birth injury or disease. It is presumed that minimal brain damage might cause disturbances in the coordination of the motor functions of speech. To support this viewpoint researchers have pointed out that many children have suffered from a severe infectious disease just prior to the onset of stuttering. (3) Psychological Theories. The psychological theories view stuttering as a state of arrested emotional development in which the libido has become fixed at the oral stage of development. This means that stuttering satisfies the infantile oral need and thus the person unconsciously desires to stutter. Other theories have viewed stuttering as a bad habit, or as a symptom of some severe emotional conflict. This conflict is sometimes called an approach-avoidance conflict. The person is afraid of speaking and wishes to avoid speaking, yet there is the ever-approaching need to speak. Suddenly the need to speak and the fear are of equal importance and the person "blocks," then stutters. The stuttering reduces the fear of speaking once the word has been spoken. The reduction of fear after the stuttering incident rewards the stuttering and thus the stuttering has become even deeper engraved into the person.

The treatment of stuttering should begin early. Often treatment is simply a change in the environment to make the child feel secure or help him gain faith in himself. Tranquilizing drugs often lower the tension felt by a person and make him feel more relaxed, especially in social settings. The major treatments for stuttering are designed to develop feelings of adequacy in speech situations.

Nail Biting. At one time or another probably about 1/5 of all children and adolescents bite their fingernails. The incidence appears to be even higher among stutterers, children reared in institutions, and individuals confronted with stressful situations.

Nail biting has been explained as (a) a substitute for masturbation; (b) a turning inward of hostility; (c) a fixation at the oral stage of development and (d) a method of tension reduction. Nail biters themselves explain their habit most often as a desire to keep busy, to use up excess energy, or ease anxiety connected with a stressful situation. The greater the tension the more frequent the nail biting.

Some explain nail biting as an acting out of the hostility the individual feels toward his parents or someone else.

The treatment for nail biting usually involves psychotherapy. Sometimes tranquilizing drugs are helpful especially in getting an individual through a specific stressful situation. It has been generally agreed upon by many that treatment of nail biting by restraint, bitter applications and punishment is of little value.

Tics. A tic is a persistent, intermittent muscle twitch or spasm, usually limited to a specific muscle group. Some examples of tics are blinking the eyes, twitching the mouth, licking the lips, clearing the throat, shrugging the shoulders, twisting the neck and grimacing. Usually the act is done habitually and the individual is unaware that he is performing the act. Tics occur most frequently between the ages of 6 and 14 but are common in adults. Some tics have an organic basis, but most are caused by a psychological reason.

Many adults have tics but most go unnoticed and are harmless. Tics begin to cause trouble when an individual is told about his tic by someone else and then tries to correct the tic. Many times this will cause the individual to develop an even stronger tic.

The treatment of tics involves psychotherapy directed toward more effective personality adjustment and toward the reduction of tension. Tranquilizing drugs can be used here to reduce tension. In some cases hypnosis has been used to reduce the tension and the tic.

Enuresis. The term enuresis refers to the habitual involuntary discharge of urine after the age of three years. It may occur during the day, but most often occurs at night. Many times the person dreams that he is urinating in the toilet only to awaken and find his bed is wet. Commonly bedwetting occurs from two to five times a week in a person who suffers from enuresis. The incidence of enuresis declines markedly with age and it seems to be relatively infrequent after the age of 30. It is generally believed that enuresis is considerably more common among males than females.

Enuresis may result from many causes, but more causes seem to result from psychological rather than organic reasons.

Some examples of how man has tried to determine why children suffer from enuresis are: (1) direct expression of anxiety; (2) attempt to show need for parental attention; (3) expression of hostility, often unconscious, against the parent; (4) the result of inadequate bladder capacity.

Most investigators have found that disturbed family relationships and emotional maladjustment in the background to be present in most children suffering from enuresis.

Treatment for enuresis involves training procedures, drug therapy and psychotherapy. Training procedures include restriction of liquids before bedtime and even electrical shock of the child if he wets his bed. These treatments do not seem to work and often cause more harm than good. Less primitive treatment procedures include things such as an electrified mattress which rings a bell when a few drops of urine are put on it. The bell awakens the patient and stops the urinating. This treatment cured 14 out of 20 cases of enuresis. Drug treatments have been used to inhibit bladder emptying, although these are used in rare cases. Psychotherapy seems to offer the best results with the best prognosis. The psychotherapy sessions usually involve the child, the doctor and the parents. The reason the parents attend is because many times they are the cause of the child's problem and sometimes must be changed themselves.

NOTES:

PATHOLOGICAL PERSONALITIES. Pathological personalities are those personalities which involve people who are neither neurotic nor psychotic but manage to maintain a borderline adjustment which might resemble a mental illness when put into a stressful situation.

The personalities which we shall discuss are schizoid, paranoid, cyclothymic, and inadequate personalities. These personalities are termed as being basically maladaptive. These individuals often have physical abnormalities, and these individuals are highly resistant to therapy. The causes of this type of a personality will not be stated nor will any treatments be presented. The causes are usually deep seeded and result because of a poor or maladjusted development. The best procedure used to find out the cause of these personalities is psychoanalysis. The specialist will not be concerned with digging this deep into a person's past nor in using psychoanalysis. The specialist is concerned primarily with the patient's behavior and this is what will be discussed in the following paragraphs. These personalities will be described so that the specialist might be able to recognize these individuals.

Schizoid Personality. As the word schizoid implies, under the proper stressful situation this individual might resemble a schizophrenic. The schizoid personality has been described as being cold, aloof, avoiding social contact, inability to express hostility, fearful, avoiding competition, and a daydreamer. This person has no close friends and usually wishes to be alone. As a child this individual was probably very shy and as puberty approached the individual became even more introverted and seclusive. In the military, this individual will find life stressful due to lack of privacy and later might show symptoms of Schizophrenia. This individual if sent to the psychiatric hospital will not be diagnosed as a true schizophrenic because he has suffered no real break with reality.

Paranoid Personality. This individual resembles the schizoid in all areas except he tends to project his hostility and feelings onto others. This person is usually very jealous, suspicious, stubborn, and envious. This person will have difficulty in the military especially when rank is concerned. This individual is usually a constant loud complainer and might end up on the psychiatric ward because of his loud complaining and fear that he is being persecuted by others.

Cyclothymic Personality. This individual over-reacts to situations. This person will have a wide mood swing from elation to depression. The mood swings will be brought on usually without adequate external cause. These mood swings are due to internal stress and not an external force. When this person is under extreme tension they might react like a person suffering from depression or like someone who is a manic. The major psychotic disorder that they would resemble, then, would be a manic-depressive psychosis.

Inadequate Personality. This person would commonly be called a "bump on a log." His personality is very dull and "blah." This person cannot react to stressful situations caused by intellectual, emotional, social and physical demands. This individual usually uses poor judgment and is unable to attain any goal. They usually have no ambition or initiative. These individuals are common in society yet go unnoticed because they are never noticed. In the military they are sometimes noticed and sent to the psychiatric ward suffering from "failure to conform." These individuals will usually be released from the service as being unadaptable and live a life of quiet seclusion.

PSYCHOPATHIC PERSONALITIES. This group of personalities contains individuals whose personality is marked by a lack of ethical or moral development, with an inability to follow approved modes of behavior. They are frequently in trouble, profit little from experience or punishment, and maintain no real loyalties to any person, group, or code. A person is usually considered to be psychopathic when he has no respect for society and its laws and codes. All of the individuals in this category have such a quality. The individuals also exhibit other common forms of behavior. They are:

a. Rigidity - the individual tends to solve all problems the same way. The most popular way is to "act out" his conflicts. Rigidity does not refer to the person's physical appearance, but to his mental state. These persons cannot deviate mentally from their one lone way of handling all problems.

b. Inability to set long-range goals - this means these persons do not have a real, long-range goal in their life. Most individuals want to be a doctor, lawyer, teacher or something which they must work to attain; psychopathic persons are not able to plan for such a goal. They will not take a job because of advancement possibilities but will take a job only to satisfy an immediate need.

c. Inability to postpone gratification of desires - "I want what I want when I want it" is the motto of this individual. This individual lives for today and works on the "pleasure principle." Pleasure is his daily goal and he might resort to stealing to satisfy this desire.

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d. Defective Conscience - this person is often called a "moral moron." This means he cannot make an intelligent decision concerning morals or social ethics, and if he makes a decision he feels no guilt if it is the wrong choice.

e. Inability to learn from past mistakes - these individuals tend not to learn from ordinary life experiences or punishment. This person often behaves as though he is immune from the consequences of his actions.

f. Lacks insight - this person is quick to blame others for any of his faults. He will lie readily even when it is obvious he will be found out.

g. Ability to manipulate - this person can put up a good front to impress others. He is often charming, friendly, and usually has a good sense of humor. This person will use others to further his desires with no remorse about hurting others.

NOTES:

Antisocial. The first psychopathic personality to be discussed is called the antisocial individual. This individual sets the guidelines for defining most psychopathic individuals. He may not have all of the above mentioned symptoms, but he does contain most of them. These individuals are almost always extremely charming and very skillfull at manipulating individuals. These individuals are impulsive and seek to satisfy only immediate interests without concern of social consequences. They have no feelings of guilt. One type of antisocial personality which is very interesting is the imposter whose exploits are often very dramatic and exciting.

One study was done on 40 antisocial individuals in an effort to find out if they had any similarities which might account for their personalities. The majority of the cases were found to have come from a family where the mother was overindulgent and the father was driving, critical and distant. Other researchers found the above to be true in many cases and also that there was conflict within the family and the child had quickly sensed these attitudes and conflicts.

These individuals are present on all psychiatric wards. They are usually very skillful at manipulating the staff and the other patients. Most workers in the field of psychiatry find that they have to be very aware of these individuals or they will be manipulated into letting this patient break rules and do other things not allowed by other patients.

The treatment of these individuals is very difficult. These individuals are not mentally ill and therefore cannot see why they should change their manner of behavior. The military uses psychotherapy in an effort to help the individual to control his behavior. The major goal of the military is to have these individuals released from the military by an administrative 39-12 separation.

Dyssocial Personality. These individuals are a product of a lifelong environment which has fostered social values in conflict with the usual codes of their society. Here we find gangsters, racketeers, and other professional criminals who usually emerge from criminal homes or neighborhood environments in which deviate codes of behavior and criminal models have served as the guides.

A study was made in 1944 and found that 10 percent of the boys who appeared in Children's Court in New York City were vicious, hardened, aggressive, habitual delinquents who chose their behavior as a career and used their gang as protection, comfort and training. Al Capone, Dillinger, and the members of Murder, Inc., are examples of the extreme forms of the dyssocial personality.

With delinquency playing such a large part in society, it should be very clear that some of these individuals eventually end up in the military. Some are given the choice of the military or prison. Of those who enter the military some adjust, but some do not adjust and continue their delinquent practices while in the military. Eventually these individuals will have conflicts. These conflicts might cause the individual to be sent to the psychiatric ward of a military hospital, usually for psychiatric examination. The Psychiatric Ward Specialist now must be ready to take care of an individual who by many is already considered to have criminal features or characteristics. The major therapy used in the military for these individuals is psychotherapy. The major goal of the military psychiatric service is to discharge these individuals under administrative actions such as a 39-12 discharge.

Sexual Deviants. Every social group and every country has its approved and disapproved sexual patterns and its sexual deviants. In some parts of the world polygamy, prostitution and extramarital sexual sexual relations are considered quite normal, whereas they are not approved by us. Sexual deviation is defined as any method of obtaining sexual satisfaction which is disapproved by the community. The sexual deviation which we shall discuss are the ones which this country does not consider normal.

Most deviations are of a private rather than a public nature, and therefore they are usually not reported. Of sex offenses reported to the police, extensive studies show that only about 15 percent lead to conviction and about 5 percent to prison commitment. These low numbers are a result of false reports and the reluctance of victims to prefer charges.

A breakdown of statistics concerning the most frequent types of sexual deviations reported to the police appear to be peeping (voyeurism), exhibitionism, incest, rape (including statutory rape), molesting, assault with sex intent, and homosexuality. Most sex crimes are committed by young, unmarried males.

There are many common misconceptions concerning sexual offenders which many people have. A few of these misconceptions will be stated below. The reason they will be stated is to help the specialist to remain objective in working with these people and to not be influenced by many myths which are untrue concerning sexual offenders.

Many individuals feel that sex offenders are homicidal fiends; in reality only 5 percent of all sex crimes involve physical injury. Another misconception is that sex offenders usually progress from less serious crimes to more serious sex crimes. The truth here is that most sex offenders continue to use the method which they have found to be satisfying.

Many feel that sex offenders are all oversexed; most are undersexed and even prudish and must resort to their sexual deviancy to fulfill satisfaction.

One of the biggest misconceptions is that sex offenders suffer from glandular imbalances. Studies have shown that sexual behavior is determined by kinds of experiences and interpersonal relations rather than by a hormone imbalance.

The last misconception to be discussed is that sex offenders are usually repeaters. Less than 10 percent of those arrested for sexual crimes are arrested again for sex crimes. Sex offenders learn rather quickly what behavior will be tolerated and what will not.

The next portion of this book is a brief description of the sexual deviations which occur frequently in society. Many of these deviances will be seen on the psychiatric ward of the military hospitals. The deviances listed are the most common and are not all of the deviances.

Homosexuality. This deviancy involves erotic relationships between members of the same sex. There is no clear cut distinction between a person being either homosexual or heterosexual. These represent the two extreme poles of sexual behavior; what is in the middle is a combination of homosexuality and heterosexuality. Studies have shown that about 37 percent of all males have had a homosexual experience at some time in their life. Only 4 percent of males are exclusively homosexual from adolescence on. Another statistic shows that 50 percent of males who remain unmarried to age 35 have had homosexual experiences since the onset of adolescence.

Homosexuality has been in man's society ever since the days when Greece and Rome ruled the world. Even such notables as Alexander the Great and Michelangelo were considered homosexual. Some societies recognize homosexuality as a part of society and do not condemn homosexuals. Homosexuals in our society are often arrested, imprisoned or sent to mental hospitals.

The military does not accept or condone homosexuality. When an individual is proven to be a homosexual in the military, he will be discharged administratively via AFM 39-12. Often an individual will be sent to the psychiatric ward for reasons other than homosexuality when he is in fact homosexual. These reasons could be depression, suicidal attempt, or evaluation. Many times the homosexual lives in fear of disgrace, is continually feeling insecure, apprehensive, and lonely. These feeling might lead to mental illness due to his guilt feelings. The hardest job for most psychiatric ward specialists to do is to not be "turned off" by a person's homosexuality, but to accept his behavior. Most homosexuals are not sent to the psychiatric ward because of homosexuality, but once the person is hospitalized for some other reason homosexuality may be found to have caused the mental condition which led to admission.

The treatment of the homosexual is complicated by society's feelings toward him, and by his feelings toward himself. Most homosexuals feel they were born homosexual and cannot be changed. Psychotherapy is used in the treatment of homosexuals though most often it fails to achieve any progress. Some therapists feel that it is more practical to encourage the homosexual to accept his homosexuality rather than to feel frustrated and guilty because of his homosexuality.

Transvestitism. This is a persistent desire to dress in garments of the opposite sex and feelings of discomfort when dressed in clothing of one's own sex. The dressing in clothes of the opposite sex is associated with sexual excitement.

A person who is a transvestite is not always a homosexual although the majority are. The reason a man might desire to dress as a woman might be because he is homosexual and wishes to make himself more attractive to other men. In many cases, a transvestite will request surgery to assume the role of the opposite sex.

These individuals may be found on psychiatric wards and many may not be homosexuals. Many times a transvestite will wear the clothes of the opposite sex on areas of the body where others might not notice, such as a man wearing women's hose.

NOTES:

Fetishism. In fetishism there is a centered or sexual interest upon some part of the body or upon an inanimate object, such as an article of clothing.

The range of fetishistic objects range from body areas such as breasts, hair, ears, hands, and articles such as underclothing, shoes, handkerchiefs, perfume and stockings.

In order to obtain these articles the person might resort to burglary, theft, or even assault. The most common stolen articles are women's underthings.

Pedophilia. In pedophilia the sex object is a child or young adolescent. The pedophiliac varies widely in terms of age, educational background, and the circumstances which surround his offenses. Most of the older offenders have been or are married and many had children of their own. The average age of the pedophiliac is 40 years of age while the average age of the victim is 7 to 10 years.

Next to the rapist the pedophiliac is the sex offender most likely to use force to perpetrate his behavior.

Many times the pedophiliac and the victim know each other - most offenders are neighbors, friends of the family, or even family members.

Voyeurism. This is sexual pleasure through peeping. These "Peeping Toms" usually concentrate on females who are undressing or on couples engaging in sexual relations.

A "Peeping Tom" first develops because viewing of the body of a female seems to be quite sexually stimulating, as evident by the popularity of pictures and drawings of nude and seminude women in books and in movies. The voyeurist seems to be stimulated by "looking" or "viewing" of the body, but is unable to carry on normal sexual relations because of feelings of inadequacy or shyness. The individual has his curiosity increased by the sight of nude women and seems to be satisfied to accept the partial goal of peeping. The individual might be driven to peeping because he feels that approaching a member of the opposite sex would be traumatic and lead to lowered self-status.

Exhibitionism. In exhibitionism sexual pleasure is achieved through exposure of the genitals in public or semipublic places.

Exhibitionism is most common during the warm spring and summer months and occurs primarily among young adult males.

Exhibitionism among women is relatively rare.

There are apparently three major dynamic factors underlying exhibitionism. First the exhibitionist seems to represent an immature approach to the opposite sex based upon inadequate information, sinful ideas toward masturbation and sexual relations, marked feelings of shyness and over attachment to the mother. The second factor seems to be a strong need to demonstrate his masculinity. This is caused usually from the maternal overprotection. and a strong female identification. The third factor is one of hostility; either toward the opposite sex or society in general. Instead of being able to use other defense mechanisms, the exhibitionist acts out his hostility by exposing himself.

The major treatment used for these individuals is psychotherapy, and they seem to respond well. The major objective is to help the person assume a healthy heterosexual adjustment. Punishment is usually useless and might even be harmful to the person.

Sadism. This term is derived from the name of the Marquis de Sade, who for sexual purposes, inflicted such inhuman cruelty on his victims that he was eventually committed as insane. The term has been broadened to include cruelty in general, but for our purposes, we shall restrict our use of the word to indicate the achievement of sexual gratification through the infliction of pain upon someone else. The pain may be inflicted by use of physical methods such as biting, whipping, pinching, or other methods; or the pain may be inducted by verbal means such as humiliation and criticism. Sadistic behavior is most common in the male.

Sexual sadism is usually one expression of a more general destructive and sadistic attitude toward others. The sadistic person usually looks at sex as being sinful or degrading, and may feel his sadism is punishing others for engaging in sexual behavior.

Masochism. In masochism the individual attains sexual pleasure through having pain inflicted on himself. The term is derived from the Austrian novelist Leopold V. Sacher-Masoch, whose fictional characters dwelt lovingly on the sexual pleasure of pain.

Masochistic activities might be ill treatment which are sexually stimulating or may involve activities such as binding, trampling, spanking, switching and verbal abuse.

Masochistic behavior is more common in women than men. This is presumably due to the fact that a certain degree of sexual submissiveness related to suffering is more characteristic of the female than of the male in our culture.

The psychopathic personalities which have been covered so far have been: antisocial personality, dyssocial personality, and sexual deviants. The last psychopathic personality is the addict.

Addiction. Addiction is usually of two kinds: addiction to alcohol and also to drugs. The reason that addicts, both drugs and alcoholic addicts, fall into the category of being character disorders is because they demonstrate the basic signs and symptoms of character disorders, especially the symptom of a pathological personality.

Drug addicts and alcoholics will be seen on every psychiatric ward, and in some cases constitute a majority of the patient load.

IMMATURE PERSONALITIES. The immature personality results from an inability to maintain emotional balance in a stressful situation. When a stressful situation arises the person with an immature personality is likely to show signs of regression rather than that of a psychosis. Some of the signs of the regression are childlike behavior patterns such as temper tantrums and crying spells.

Passive-Aggressiveness. The first, and probably most common type of immature personality to be discussed is a passive-aggressive personality. This individual usually cannot express hostility directly; he does it passively in ways such as being out of step while marching, being late for class, or cracking knuckles in the library. They will also express hostility through pouting, stubbornness, or procrastination. Sometimes this person will show some active aggression, but it will be in the form of irritability, tantrums, and destructiveness. Many of these individuals can be found in civilian life as well as on psychiatric wards.

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Passive Dependent. This individual is similar to the passive-aggressive individual except that he does not feel the need to express his hostility. This individual feels the need to depend on others. He was usually raised as an overprotected child and when he entered the military became very homesick and needed to be dependent upon someone. These individuals will become very attached to the staff on the psychiatric ward and will be very confortable while on the ward. The staff needs to help this person become independent and needs also to make his hospital stay not too comfortable so he won't want to stay in the hospital.

Emotionally Unstable Personality. These individuals are very easily upset and excited. They cannot face even minor stressful situations without becoming easily upset. They cannot control or channel their hostility, anxiety and guilt. Because these people are so easily upset they cannot function in the military; so they are sent to the psychiatric ward to be evaluated and later discharged from the military.

Compulsive Personality. These individuals are very rigid in doing things. They are overly conscientious about doing things also. They obey all rules to the point that they worry about rules and often become angered when others do not do things exactly as they should. They feel a deep need to conform to standards. Most of these individuals cannot relax; they feel they must keep busy and when not busy worry about things they have done.

BASIC NURSING CARE MEASURES REQUIRED FOR PATIENTS WITH ABNORMAL BEHAVIOR PATTERNS

PATIENTS' PROBLEMS AND NEEDS. Some of the problems the patient has effect the patient and some effect the staff. Manipulation, the deliberate attempt to control the behavior of others in order to meet one's own needs or goals, is a definite problem the staff must face when working with a character and behavior patient.

The staff also has to beware of these patients continually trying to incite other patients into hostile relationships with the staff and patients.

The character and behavior disorder patient will also break ward and hospital rules, and the staff must be ready to deal effectively with this situation.

These patients will try to "play up" to the nurse or doctor in an effort to obtain more privileges.

The problems listed above affect the staff more than the patient but there are also specific problems and needs the patient has. One problem the patient has is that he does not believe he is ill and does not believe he should be in the hospital. The patient will look physically well and upon first meeting the patient, the staff might question the reason for hospitalization. When the staff has time to observe the patient or check the patient's records, the patient might not be mentally ill, but he might have a serious adjustment problem which does require treatment.

The patient is also usually self-centered and will take up much of the nurse's time. The patient has the need here for affection and belonging.

APPROACHES TO MEET THESE NEEDS. The approaches to meet the needs of the character and behavior patient differ in some ways in the different classifications of patients. The drug addict will be treated differently than a passive-aggressive person, but there are some similiarities in the treatment of all of these patients.

The patients need a well-planned schedule of daily activities. If the patient does not have a well-planned schedule he will tend to sit around and do nothing or will give the staff problems.

The staff should always convey the impression that active participation in social activities by the patient is expected. Games of competition are good for these patients because they teach patients to accept limitations set by rules.

The staff must be objective in dealing with these patients and rules must be enforced. Limit setting is very important because it teaches the patient that he must accept the rules of life.

TREATMENTS PRESCRIBED BY THE PHYSICIAN. By the time these patients reach the psychiatric ward, their personality is so well ingrained within their total character that most forms of treatment will not have any effect upon the person. The alcoholic and drug addict are the only persons who might receive the major benefit from treatment on a psychiatric ward, and yet the cure rate on these addicts is very low.

Medications are sometimes used to control patient behavior, but most doctors do not wish to use medication for this purpose.

Psychotherapy is the only kind of therapy which seems to have some effect upon this type of patient. The goal of psychotherapy is that the patient will receive enough insight via the therapy to result in the adoption of more flexible, socially acceptable patterns of behavior.

Questions

1. Why are the symptoms of combat exhaustion not seen on the psychiatric ward?

2. How does a character disorder differ from a behavior disorder?

3. Explain the approach-avoidance conflict in stuttering?

4. What is a pathological personality?

5. Define psychopathic.

6. What does the term "rigidity" refer to in a symptom of a character and behavior disorder?

7. Differentiate between antisocial and dyssocial.

8. Most sex crimes are committed by whom?

9. In your own words, define passive-aggressiveness.

10. Why are games of competition good for a character and behavior disorder?

11. How can you protect yourself from being manipulated by a character and behavior disorder?

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-12C

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

NURSING CARE AND APPROACHES FOR THE ALCOHOLIC AND THE DRUG ADDICT

July 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

SW 3ABR91431-2-II-12c
July 1975

NURSING CARE AND APPROACHES
FOR THE ALCOHOLIC AND DRUG ADDICT

OBJECTIVE

Describe the problems and needs of the drug addict and alcoholic and the approaches used to meet these needs.

SECTION I

INTRODUCTION

Every person who drinks is susceptible to an alcohol addiction that can begin at any age. Most alcoholics are ordinary, responsible, productive members of the community and only 3% of all alcoholics are on skid row. The signs of this well hidden illness are not apparent until the disease changes the person's behavior and affects his health, family and job. Almost all alcoholics can respond to treatment.

A beer, a cocktail, a party, social drinking, morning drinking, craving of a drink and then alcoholism. This problem is common not only in civilian life but the military as well. You will be working with this type of patient on the ward. What is he like? How do you care for some one in Delirium Tremens. Could I have this problem because I have "a few drinks?" These are some questions you may think about when you study this SW.

INFORMATION

Read Textbook for Psychiatric Technicians, pages 214-223. Read this SW and answer questions at the end of this section on the alcoholic.

ALOCOHOLIC

Patterns of Behavior Demonstrated by Mental Health Patients (Alcoholism)

ALCOHOLISM. By definition, an alcoholic has a personality disturbance in which the most prominent symptom is the overuse of alcohol to the extent of habit, dependency or addiction.

A DISEASE. Often alcoholics are labeled as having a disease, which has been useful in getting away from the moral aspects of drinking and allowing the alcoholic an equal chance at the therapy he needs. The disadvantage of this is told by alcoholics themselves, that there is an organic metabolic dysfunction operating as the primary cause of alcoholism. This is unfortunate as it tends to allow the alcoholic to excuse himself from the responsibility to seek help for psychological causes of his drinking. There have been many scientific studies both to determine if alcohol has a psychological origin or if an organic factor is involved. It is more important for you to detect the stages of withdrawal the alcoholic goes through and what nursing care measures you can use rather than the cause of alcoholism. Lets now turn to how alcohol has affected society.

SOCIETY ASPECTS. On our nation's highways alcohol contributed to one half of all our traffic deaths. Forty percent of all arrests are for alcoholic intoxication. Big business spends over 2 billion dollars a year due to the absenteeism of employees from abuse of alcohol. In lower income groups male alcoholics outnumber females five to one. It is interesting to note however, that in the upper income bracket the ratio is

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This supersedes SW 3ALR91431-II- 12c, February 1975 fifty-fifty, male-female. Fifteen percent of the patients who slip into Delirum Tremens die from this condition. (Delirium Tremens is an acute toxic reaction which occurs in patients who have used alcohol heavily over a prolonged period of time.) Some of the facts are here but more important how does a person become an alcoholic?

COMMON MANIFESTATIONS AND BEGINNING SIGNS. The alcoholic gets into a pattern of excessive compulsive drinking which leads to a chronic state. For most alcoholics the amount of liquor that must be consumed grows steadily. You may have heard of Lillian Roth, a famed movie actress who wrote an autobiography called "I'll Cry Tomorrow." Beer by day and liquor by night satisfied her until her nerves seemed to demand more. Soon she had to have a morning beer; this did not satisfy her craving, so she added two ounces of bourbon to her morning orange juice. One morning while out shopping with a friend she had a dizzy spell and almost collapsed. A cab driver advised she carry a shot or two around with her. She bought 2 ounce medicine bottles and filled them with liquor and put them in her purse. Eventually this was not sufficient and 2 ounce bottles became fifths and a larger purse. This led physically to her loss of functions and she became desperately sick in the form of "the shakes" which led to physical agony. The pain was in all parts of her body, the head, chest, stomach and legs. Liquor could relieve the pain but the body even rejected that and this lead to delirium tremens.

Psychogenic Factors

ANXIETY SOOTHER. Anxiety is constant to people all over the world and alcohol is also universal. The use of alcohol must exist because it satisfies some deep seated psychological need. This need being the relief from tension resulting from difficult experiences and conflicts.

A well adjusted person can cope with his anxieties without resorting to drinking which may seriouly disorganize his personality. If the person's capacity for dealing with frustrations, tensions, guilt, resentment and other anxiety producing feelings and experiences is low, he may turn to drinking to relieve and soothe anxieties. Anxiety serves to create a continual circle of the drinker's habit. Alcohol relieves anxiety and at the same time creates new problems for the individual which leads to new anxieties and further drinking.

RELIEVES INHIBITIONS. You may have seen a mild mannered person after three drinks become sexually aggressive. But at the end of an evening he may be quite helpless and have to be helped home and put to bed. Perhaps later leading to a sense of remorse and guilt.

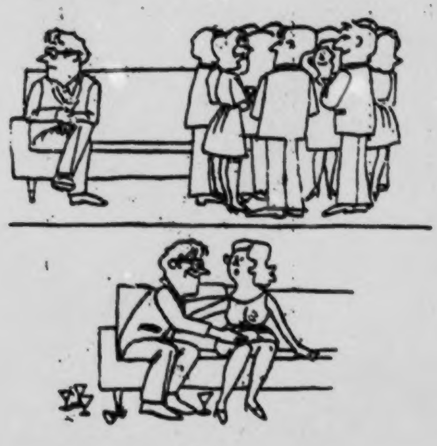


Fig. A

Common Mental and Personality Changes

EGOCENTRICITY. This is the first trait of the alcoholic. He becomes so engrossed and wrapped up in his own problems and concerns that he is indifferent to the needs of others. This can be compared to a child in early infancy when his own gratification is the only reality. The alcoholic's primary concern is getting a drink.

PARANOID IDEAS. Usually characterized in the alcoholic by jealously, accusations to the spouse of marital infidelity. He misinterprets offers from friends to help him as if they were picking on him.

AMBIVALENCE OF FEELINGS. He may have alternate feelings of seeking and rejecting help; the desire for help by someone and the want for alcohol in opposition. Often he presents both love and hostility to the family and in his drunkeness may harm them physically.

The hostility is usually displaced to the person they are dependent upon and is closest to them. But these hostilities are repressed when he is sober. Some alcoholics suffer excessive guilt and remorse from partial release of this hostility under the influence of liquor. They remember hallucinations and dreams of harming someone during a drinking bout or may be afraid of what they have done during a blackout. Occasionally repressed hostility may release itself during the acute intoxication but no radical behavior change occurs.

INCONSISTENCY. He may show excessive deviations in behavior often impulsive and undependable at home, work and with friends. He tends to withdraw or become disorganized when faced with frustrating situations. There is no set goal and he avoids troublesome situations. He cannot tolerate being rejected and makes up stories to avoid unpleasantness.

LACK OF INSIGHT. This is the most predominent of personality changes. Usually the base assignment and supervisors get the blame and he uses these as a scapegoat to justify his need to drink. He tries to rationalize that he can control his drinking.

MOOD OF DEPRESSION. After a binge with drinking he may have feelings of guilt, remorse and self-accusation. These strong feelings of depression can lead to suicide attempts or he becomes very prone to accidents. When admitted he usually appears depressed, tense, fearful and pessimistic and may avoid talking about drinking.

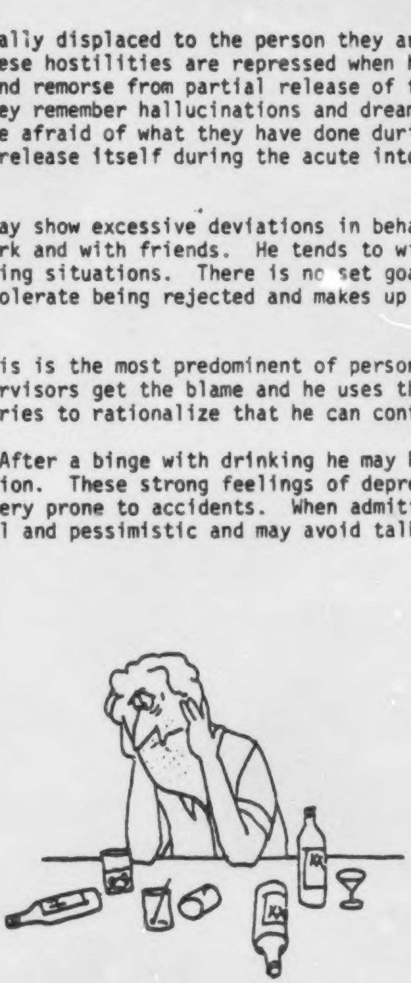


Fig. B

Physiological Effects

If you have ever consumed an alcoholic beverage, you may notice that a warmth begins to flow quickly through your body. The alcohol is absorbed directly and rapidly into the blood stream, and eliminated slowly from your system. The higher brain functions such as judgement, memory, self-criticism and awareness of the environment are influenced first. The drunken driving offenses reflect how judgement is affected by alcohol. If you smoke and drink you may have had two cigarettes lit at the same time without remembering you had one cigarette already burning.

Basic Nursing Care Measures Required for Patients With Abnormal Behavior Patterns

SIGNS AND SYMPTOMS

Acute Intoxication.

These signs and symptoms vary with the personality and quantity of alcohol and are similar to drunkeness.

Muscular uncoordination and slurred speech.

Judgement and intellectual activity are impaired.

Memory is less sharp than usual.

The end result may be a stupor or a coma.

It is possible that an acutely intoxicated patient may develop DTs.

DELERIUM TREMENS (DTs). This is an acute toxic reaction which occurs in patients who have used alcohol heavily over a prolonged period of time. In the care of the alcoholic you should be aware of the different stages of DTs and the seriousness involved in caring for this patient.

EARLY SYMPTOMS. Usually DTs appear 24-72 hours after the patient has had his last drink. He is restless and irritable and may become argumentative for small insignificant reasons. He has no appetite, suffers from insomnia and may perspire only slightly.

SYMPTOMS PROGRESS. As the symptoms progress, the patient will have slurred speech, tremors of the hands and prominent facial muscles, and be unable to walk without support from the wall or someone else. He will be disoriented and confused as to the time and place. Usually he realizes he is in the hospital because of the white uniforms - but which hospital he is in may be confusing to him.

LATE SYMPTOMS. Next we go to the late symptoms in which the most prominent sign is excessive sweating. The sweat will pour out of his system so much the pajamas will have to be changed periodically. This is accompanied by a rapid, weak and thready pulse and an elevated temperature.

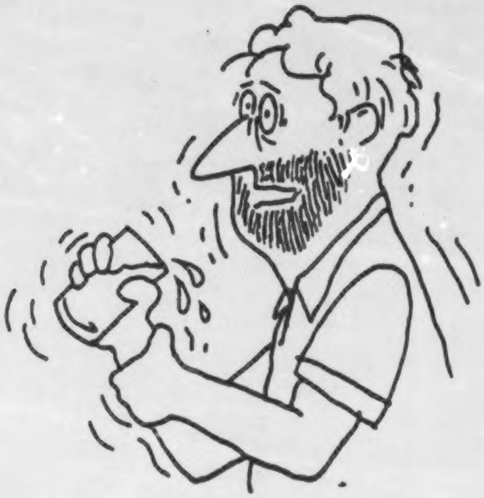


Fig. C

DANGER PERIOD. Now comes the danger period, or commonly known as the full blown DTs. The patient has uncontrollable shaking in which he cannot hold a cup of water to drink. The shakes are so bad he will empty the glass of water before he gets it up to his mouth to drink. Both auditory and visual hallucinations are pronounced in this stage of DTs. They can carry on conversations for hours with no one else being present in the room with them. Common hallucinations the patient sees are insects and animals such as spiders, bugs, snakes, skunks, cats and birds. These are predominent in the evening and nights when shadows appear. In a panic state, the patient may attempt suicide in a reaction to auditory hallucinations. About 15 percent of DT victims die from uncontrollable convulsions.

CARE OF THE PATIENTS IN DTs. It is important to check the alcoholic upon admission for alcoholic beverages.

Observation of the patient to determine if the patient is in any distress or going into DTs. Observe if visitors or other patients bring alcohol to the patient as a friendly gesture and inform them of the seriousness of the patient's problem with alcohol.

PROTECTION. Protect the patient by keeping the side rails up while the patient is in bed in case he may have a convulsion. Watch for suicidal ideas and keep all razors and sharps away from him while he is in DTs. Restraints may be necessary to protect him from injury.

MEDICATION. The patient is given drugs to prevent exhaustion and convulsions.

VITAL SIGNS. The patient's TPR and BP are taken at least every 4 hours.

INTAKE. Fluids should be forced into this patient as he perspires constantly and needs fluid replenishment to maintain the balance of body fluids. The intake should be at least 3 quarts a day and can consist of juices, water, soft drinks or any nonalcoholic beverages. You may have to spoon feed the patient, but show concern, be firm, and you should find it easier to feed him.

REASSURE THE PATIENT. Frequently remind the patient that he is in the hospital. Give the patient your full support.

PATIENT'S PROBLEMS AND NEEDS

Problems:

Impaired thinking.

Feelings of guilt.

Loss of willpower.

Loss of interest in friends and relatives.

Troubles with job and finances.

Moral and physical deterioration.

Needs:

You can help the patient the most in these areas.

Mutual help and group therapy.

Help him use realistic thinking so he can face the facts with courage.

Help him gain self-esteem and develop new interests through O.T. and R.T.

Get them started with care of personal appearance.

Encourage regular sleep habits and three square meals a day.

APPROACHES TO USE TO MEET THESE NEEDS. The first approach is to accept the alcoholic as a person with an illness that he cannot manage by himself. This is not a moral problem and he will reject lecturing, he has heard the"no, no" many times. Show that you have a sincere interest in him yet not overly permissive. Throughout your approaches you can decrease the patient's need for dependency and encourage independence.

TREATMENTS AND PROCEDURES PRESCRIBED BY THE PHYSICIAN. The first treatment is to "dry out" the patient and give medical treatment to complications usually of the liver, stomach and possibly pancreatitis. To help gain insight into his personality and deal with conflicts, group therapy is prescribed. The physician should work with the family and spouse to assist the patient to regain his responsibilities in the home.

A new program for alcoholics in the Air Force has been established recently. The patient must volunteer hospitalization for a composite 14 day treatment and subsequent followup at six month interval and monitoring of his progress thereafter.

At the time the patient volunteers for this treatment he can have no disciplinary action pending against him.

Alcoholics Anonymous

Alcoholics anonymous is commonly referred to as A.A. and its members' identity is kept to a first name basis and as the name implies remains anonymous. The only requirement to become a member is a desire to stop drinking. It is a self supporting organization dependent on each group's own contributions usually obtained by passing the hat. A.A. is not affiliated with any religious, political, sect, organization, or institution.

There are no pledges the A.A. member takes that state he will not drink again. Instead they try to follow a 24 hour plan which means to concentrate on staying sober for the present 24 hours. It is a simple process of trying to get through one day at a time without a drink. If the urge to drink comes on, the idea is to neither yield nor resist but simply put off taking that particular drink until the next day. Today is the only day they worry about - say alcoholics. It is realized that even the most severe drinker can go for 24 hours without a drink. The inference behind it is if an alcoholic can delay a drink to the next hour or even the next minute he can learn to put it off for a period of time.

The temptation to drink usually fades after the first few months in A.A. The choice between drinking and nondrinking is entirely up to the person, if he wants to get drunk he does. However, all members are made aware of that decision to drink. Is it worth all the consequences experienced from past drinking?

The Spouse - An interesting factor is the role the spouse of the alcoholic plays. As an example: Many wives married their husbands to satisfy an unconscious need to be a mother and take care of the husband when he gets sick and helpless. Subtly the wife may try to defeat her husband to maintain sobriety in fear that he would become mature and self-sufficient and thus not need her motherly love. This is a common problem and a group related to A.A. has developed, called "Alanon" where both husband and wife can get support in making healthy adjustments in understanding each other's needs.

Summary

The alcoholic needs a lot of attention and nursing care during his delerium tremens. But once he has recovered from the DTs you will feel you have helped this person rebuild himself.

Questions

In the following fill in the blanks or answer the question.

1. Under ambivalence of feelings the alcoholic usually ______________________________

hostility on the person they are ____.

2. The most predominent personality change in the alcoholic is ____________________

____.

3. Alcohol affects the higher brain functions first. What are these four brain functions?

a. ____.

b. ____.

c. ____.

d. ____.

4. Delirium Tremens usually appear within ______________________ hours after last drink.

5. The most prominent sign of the late symptoms of DTs is ______________________

____________________________________.

6. In the danger period or full blown DTs the patient cannot ____________________

____________________________________ drink.

7. Both ________________________ and ________________________________

hallucinations are pronounced in the danger period.

8. In care of the patient in DTs his intake of fluids should amount to at least______

____________________________________ a day.

9. Throughout your approaches with this patient you should decrease the patient's need

for ______________________________ and increase ________________________.

10. What is the 24 hour plan for the A.A. member?

SECTION II

INTRODUCTION

The World Health Organization defines drug addiction as a"state of periodic or chronic intoxication produced by the repeated consumption of a drug." Of the many drugs and substances which people use, those which affect the mind and produce a change in mood or behavior offer the greatest potential for drug abuse.

Drug abuse is a growing problem. Thousands of Americans, both young and old, endanger themselves and others through the inappropriate use of drugs of all kinds. More than 100,000 of these people lead totally unproductive lives because of their addiction to drugs.

Read this Study Guide and Workbook and answer questions at the end.

INFORMATION

Most drug addiction involves the narcotic drugs such as morphine and its derivatives (heroin, codeine), the hypnotics, and sedatives (barbiturates, marijuana). Drug addiction usually signifies an escape from the realities of life and is generally found among the emotionally unstable, the immature, and occasionally the thrill-seeking individual. Addiction is sometimes acquired as the result of an illness when, because of pain or insomnia, drugs have been given over a long period of time.

Drug addiction most often begins when an individual is urged to try drugs by someone already addicted or by an illicit dealer. This traffic in drugs is completely illegal and often, before he knows it, the innocent and usually young person is involved and feels that he cannot escape.

THE DRUG ADDICT

Drug Addiction

Addiction is characterized by

- an overpowering desire to continue taking the drug.
- a tendency to increase the dosage.
- psychological and physical dependency on the drug.
- detrimental effects to both the individual and society.

The drugs most commonly associated with addiction in the U.S. are the opium derivatives (morphine, heroin, paragoric, codeine), synthetic counterparts of these drugs, and the barbiturates (bromides, barbital, phenobarbital).

Habituation

Habituation is characterized by the following:

- There is a desire but not a compulsion to continue taking the drug.
- There is little tendency to increase the dosage.
- There is some psychological but no physiological dependence.
- Any detrimental consequences effect the individual.

The drugs associated with habituation are cocaine, hashish, amphetamines, benzedrine and LSD.

Now that we have seen the difference between addiction and habituation, lets look at some of the effects drugs have on people.

Patterns of Behavior

When persons are engaged in taking drugs, in many cases the person's behavior changes.

There is a sudden or radical change in discipline, habits, grades (if in school) and in appearance. He becomes increasingly secretive regarding his possessions. This is due to hiding drugs and fear of the drugs being detected.

When taking drugs, most people will have dilated pupils; to hide this sign the person will wear sun glasses. Association with known users is a good indication a person may be considering taking drugs or already involved in drug abuse. In order to purchase drugs the user may have to sell his possessions, borrow or even steal to support his dependence.

Effects of Opium

Morphine and heroin are the principle derivatives of opium. They are most commonly introduced into the body by smoking, eating or by hypodermic injection.

The immediate psychological effects are

- lessening of voluntary movement.
- decrease in sexual desire.
- drowsiness
- miscroscopic sense of time and space.
- relief of pain
- euphoria, with feelings of relaxation and contentment.
- day dreaming.

The pleasant effect lasts from 4 to 6 hours and is followed by a phase which produces a desire for more of the drug.

If the users of opiates do not get another dose of the drug in 4 to 6 hours, they start to experience what are called withdrawal symptoms. These are characterized by yawning, sneezing, sweating and anorexia, followed by the increased desire by the drug, restlessness, psychic depression, irritability, muscular weakness and an increased respiration rate.

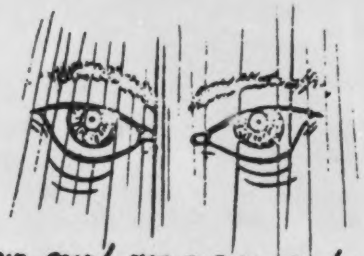
VIOLENT BEHAVIOR MAY RESULT....

[illegible] UNKEMPT & [illegible]

BIOLOGICALLY [illegible] [illegible] [illegible] BODY RESERVES & MAKES THE USER EXTREMELY VULNERABLE TO DISEASE.

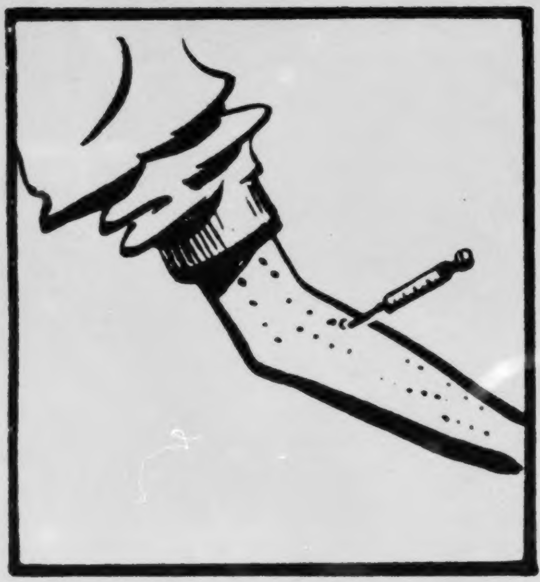
Signs and Symptoms

o A sign to be aware of, when dealing with drug abuse patients, is pin point eye pupils and pallid complexion. This sign is more prominent when a person is taking morphine or heroin.



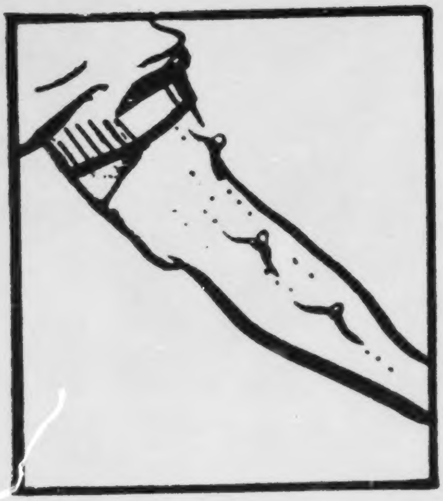
Pin-point eye pupils and a pallid complexion..

o "NEEDLE TRACKS." Some drugs are taken by injection. The drug is injected into a vein of the body. The most used sight of injection is the areas of the arm. But, this does not necessarily mean that this is the only sight of injection. There have been cases when needle tracks were between fingers, toes, in the groin area, and even along the veins of the head.



"NEEDLE TRACKS"

(small needle marks) usually over a vein on arms or legs..



ABSCESSES (boils)

at the site of injections. Dirty needle diseases are common among users: Hepatitis, septicemia and infection on the heart values.

Effects of Barbiturates

Barbiturate drugs, common in the form of sleeping pills, are used in large quantities in the U.S. These drugs involve the building of tolerance and physiological dependence and are true drugs of addiction.

The predominant signs of excessive usage are depression and impaired reasoning. Problem solving and decision making require great effort and the individual is aware that he is thinking "fuzzy." Prolonged usage of barbiturates leads to brain damage and mental deterioration.

Effects of LSD (Lysergic Acid Diethylamide)

The most common and most abused drugs today are the hallucinogens, also called psychodelics. These are drugs capable of provoking changes of sensations, thinking, self-awareness and emotions. The most prominent effects of LSD are an alteration of time and space perception, illusions, hallucinations and delusions, depending on the dosage.

The number of persons on these drugs or on a so called "high" is unpredictable. These persons do things, while under the influence of the drug, that they would probably not do if they were not under the influence, such as walking into traffic or trying to fly out of a building. If the effects of the "high" becomes too overwhelming for the person, he may commit suicide.

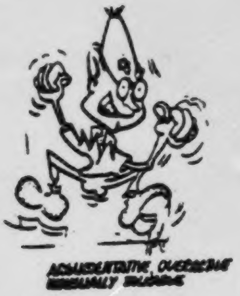
Capable of unpredictable and irrational behavior.

Flashback
COOL-IT MAN! I "turned off" LSD two years ago!

Releases Inhibitions

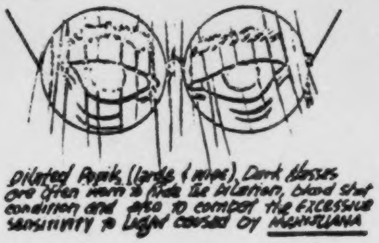
Effects of Marijuana

Marijuana is a depressant which temporarily produces a euphoric state, involving increased self-confidence and a pleasant feeling of relaxation. Under the influence of marijuana the individual is inclined to talk too much, become overactive or argumentative.


ARGUMENTATIVE, OVERACTIVE
UNUSUALLY TALKATIVE

Marijuana, even when used over a long period of time, seems to have no harmful physical effects. However, the expense of maintaining a supply of the drug and the antisocial conditions under which such supplies are obtained, may lead to undesirable changes in ethical values. No reliable statistics are available, but the use of marijuana is probably more widespread than is generally suspected.

THE USER MAY HAVE:


Dilated Pupils, (large & wide), Dark glasses are often worn to hide the dilation, blood shot condition and also to comfort the excessive sensitivity to light caused by MARIJUANA

Association with Addicts and Character Disorders

The great majority of addicts are evidently suffering from character disorders. Most often they are immature, inadequate, passive aggressive individuals. These individuals explain their addiction as pressure from peer groups and curiosity.

Teen age narcotic addiction is often associated with membership in delinquent gangs in which the use of narcotics is part of the gang culture. Usually the first shot or injection is given by the gang leader or the person's best friend, who is a gang member.

Addiction Due to Physical Illness

Many patients are given narcotic drugs such as morphine, to relieve pain during illness, following surgery or because of a serious injury. The majority of these patients don't become addicted. Addicts who blame their addiction on the use of drugs during their illness usually are inadequate, immature and have a low stress tolerance.

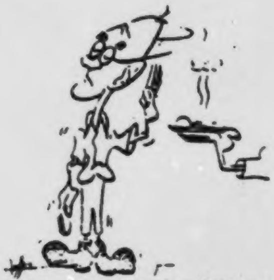
Addiction in Professional People With Access to Narcotic Drugs.

Occasionally professional people such as doctors and nurses become addicted to drugs. They may be tempted by curiosity, but more often they use the drug in an attempt to ward off anxiety or depression due to their job or family problems. This is the less common of the addiction factors.

Problems and Needs of the Addict

Persons who take drugs or are involved in drug abuse have specific problems and needs. With all the talk about drugs going on in schools and churches the younger person may want to experiment with the drug, to see if it is what everyone says it is. Another reason persons take drugs is to feel part of his group and be accepted.

When persons are abusing drugs their personal hygiene activities are reduced, which may result in physical disorders, such as rashes and malnutrition.



GENERALLY UNABLE TO EAT - NO APPETITE

During a "high" or while on a drug, things may become so bad that the person becomes suicidal, which should bring about suicide precautions on your part as the specialist. You the specialist can help the patient develop realistic thinking and relieve feelings of guilt and shame.

Nursing Care and Approaches

There are three ways to withdraw a physically addicted person from a drug.

- Abrupt; stopping immediately (cold turkey)
- Rapid; stopping within 7-14 days
- Gradual; stopping within 30 days.

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When dealing with a psychologically addicted person, the drugs should not be available. Therefore, make certain the person does not have drugs concealed on his person, or in his luggage. This should be accomplished during the patient's admission. Supplying an adequate diet and administering sleeping medications are helpful. Above all these people need understanding. The last thing they need is for someone to preach to them on the danger of drugs. By setting an example yourself, you will help the patient back to a productive life.

Summary

The flight of illegal drug traffic--the lives it ruins and the lives it takes--is a serious concern for everyone. It especially concerns you, as you will be working with these people.

Questions

1. List four reasons people take drugs.

2. Describe the effects of opiates.

3. Why are barbiturates so dangerous?

4. What are four ways you can help the person who abuses drugs or is addicted?

NAME ______________________________

DRUG ADDICTION QUIZ

INSTRUCTIONS: Read each of the following questions and circle the correct answer.

1. Which of the following may be a pattern or behavior demonstrated by a drug addict?

   a. Increasing secretiveness

   b. Wearing sun glasses

   c. Drop in grades

   d. All of the above

2. The best approach to use in working with a drug addict is:

   a. One of acceptance, understanding and companionship

   b. Encourage him to be dependent

   c. Put the patient in a room alone and let him think about what he is doing to himself.

   d. Sit the patient down and tell him what he is doing to himself

3. You should avoid arguing with a drug addict because:

   a. He is characterlogical

   b. He has an answer for everything

   c. It is a waste of time

   d. All of the above

4. It is ineffective to lecture a drug addict about why he shouldn't take drugs because:

   a. He knows that he is wrong

   b. He needs to know why he takes drugs; not that he does

   c. None of the above

   d. All of the above

5. It is important to encourage the drug addict to be independent?

   True False

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas

STUDY GUIDE AND WORKBOOK 3ABR91431-2-II-13
April 1975

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CHRONIC MENTAL ILLNESS

OBJECTIVE

Identify the behavior patterns of mentally ill persons who are chronically ill.

INTRODUCTION

Chronic mental illness is the most severe of the psychiatric disorders, rendering the patient incapable of existing in society. This disease is characterized by a marked degree of abnormality in all phases of the personality function and particular difficulty in the reality testing phase. These are progressive diseases in which the personality involved becomes progressively less able to react and adjust to the social environment.

Read Textbook for Psychiatric Technicians, chapter 14, pages 193-223. Read this SW and answer the questions at the end of this SW.

INFORMATION

DEVELOPMENT

There are no hard and fast rules for determining whether or not a person is chronically mentally ill. Many of the symptoms of the various psychotic diseases you will recognize as things which may occur in perfectly normal people. It is the number and severity of symptoms which determine whether we think a person has strayed far enough to be considered a chronic mentally ill person.

1. Identify the behavior patterns of mental health patients who are chronically ill.

Chronic means marked by long duration or frequent recurrence. The chronically mentally ill patient has a major mental disorder or organic and/or emotional origin in which there is a departure from normal patterns of thinking, feeling and acting. There may be so many thoughts at one time that the patient cannot pick one to think about. There may not be any feeling (neutral). His acting may be inappropriate and opposite to the situation.

Common characteristics of this patient are a loss of contact with reality, distortion of perception, regressive behavior and attitudes and diminished control of elementary impulses and desires. The most common abnormal mental content prevalent in this patient is the presence of delusions and hallucinations. This patient's memory intelligence and judgement is impaired, he is disoriented and his mood is inappropriate.

The patient withdraws from his surroundings such as social functions, and loses interest in work and responsibilities to the family. His interest in personal appearance, bodily cleanliness and dress declines.

This supersedes SW 3ALR91431-II-13, November 1974

Designed for ATC Course Use

DO NOT USE ON THE JOB

2. Describe the psychological impact of prolonged hospitalization on the patient's family and the community.

In the film (91st Day) on chronic mental illness you will see that the family has to struggle to get the patient the treatment he needs. They ask why the lack of intensive care for long term patients? Is it lack of facilities, money, personnel, or just general attitude of unconcern by the populace. Hospital officials and legislators are sympathetic to the family's problem but are unable to buck the tide of public indifference. The help that the family needs must first be demanded by the public through state and federal legislators, asking that mental hospitals be improved.

Family loyalty is the most vital part of the patient's successful return to the community, since the family can create the bridge between the hospital and the community.

Mentally ill persons, like all of us, need to know that they are loved, and that we are concerned about their well-being. But love and affection, although important, are not necessarily a cure for the mentally ill. We need to know more about mental illness than we do know now, even though we've come a long way.

You have just completed material on the chronic mentally ill patient. During your classroom hours, you will see a film called the 91st Day. This film emphasizes the need for progressive legislation, more dollars for mental health, Community Mental Health Centers, intensive treatment programs, more voluntary and professional manpower, more research, better patient facilities and a more informed and favorably motivated public to treat the mentally ill and to aid the families. In your hospital experience, you will take a field trip to the Wichita Falls State Hospital in which you will be able to see chronic mental patients.

Questions

Select the answer in column A that best completes the sentence in column B.

Column A - Answer

a. number
b. loyalty
c. acting
d. sympathetic
e. severity
f. chronically mentally ill
g. feeling
h. contact with reality
i. chronic
j. thinking

Column B - Sentence

1. The chronically mentally ill patient has a major mental disorder of organic and/or emotional origin in which there is a departure from normal patterns of ______________ ________________ and __________________.
2. Marked by long duration or frequent recurrence is the definition of ______________________________________.
3. Chronic mental illness is commonly characterized by loss of ______________________________________.
4. There are no hard and fast rules for determining whether or not a person is ______________________________________.
5. It is the ___________ and ______________ of symptoms which determine whether we think a person has strayed far enough to be considered a chronic mentally ill person.

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6. Family ___________ is an important item item for the patient's successful return to the community.

7. Hospital officials and legislators are ______________________ to any family problem, but unable to buck the tide of public indifference.

Department of Nursing
School of Health Care Sciences
Sheppard Air Force Base, Texas 76311

HANDOUT 3ABR91431-2-11-13
January 1976

ADMITTING THE MENTAL HEALTH PATIENT

CRITERION PROGRESS CHECKLIST

INTRODUCTION

Referring back to your study guide/workbook on "The Principles of Mental Health Nursing," you can recall the importance of the first contact with the patient. Usually, this contact is made during the admission procedure. Being hospitalized on a mental health ward brings about many anxieties, fears, and questions, which you as the specialist admitting the patient can help to alleviate by a friendly, polite, confident, hospitable attitude. During the next few years as a Mental Health Ward Specialist, you will have many opportunities to admit patients to your unit. Show the patients you do care by developing an attitude during admission that transmits your desires to help.

TASK ELEMENTS

1. Preadmission		
a. Check treatment room for equipment needed.	1	
b. Check with staff for bed assignment for new patient	1	
2. Admission Procedure		
a. Greet the patient		
(1) Introduce yourself	5	
(2) Explain what you are going to do. (Very important)	5	
b. Obtain biographical information and record on admission card.		
(1) Full name	1	
(2) Rank	1	
(3) Social Security Number	1	
(4) Religion	1	
(5) Identifying marks	2	
(6) Allergies (include medication and foods)	2	
(7) Date of birth	1	
(8) If female, her last menstrual period (LMP)	1	
c. Explain procedure for safeguarding valuables.	2	
d. Obtain and record patient's vital signs.		
(1) Temperature, Pulse, Respiration	6	
(2) Blood pressure	4	
(3) Height	1	
(4) Weight	1	

Designed For ATC Course Use

DO NOT USE ON THE JOB

e. Explain necessary ward information to patient		
(1) Doctor's name	1	
(2) Time of patient's interview with doctor	1	
(3) Time of patient's interview with nurse	1	
(4) Patient's level		
f. Orient to *unit*		
(1) Show location of clothing room and issue convalescents, pajamas, housecoat, slippers and towel.	2	
NOTE: Issue toilet articles if necessary.	1	
(2) Show location of shower and latrine facilities	2	
(3) Obtain any extra medications or unauthorized implements from the patient.	3	
(4) Have the patient change to hospital uniform;	3	
Collect previously worn uniform/civilian clothers and baggage; mark patient's name on collected materials; place materials in designated clothing area.	4	
(5) Ask patient if and when he ate last.	2	
3. Postadmission		
a. Report to staff member if patient needs a meal ordered.	2	
b. Report to staff if patient has valuables that need to be secured.	3	
c. Give staff any extra medications or unauthorized implements that the patient had.	2	
d. Turn admission card into the person in charge of making up patient's charts.	1	
e. Report to person in charge of making up charts any allergies the patient may have stated.	3	
f. On a separate index card, write a brief observation note on the newly admitted patient. Include descriptions of the following:		
(1) Affect	5	
(2) Behavior	5	
(3) Voice-conversation	5	
(4) Appearance	5	
(5) Your impression (simply stated)	5	
(6) Eye contact	5	
g. Report to the nurse any abnormalities in vital signs and the allergies.	3	
Instructor ____________ Date __________ Score	100	
Minimum Passing Score	80	

PROGRAMMED TEXT 3ABR91431-2-II-12e

DEPARTMENT OF NURSING

PSYCHIATRIC WARD SPECIALIST

REHABILITATION RESOURCES

July 1975

SCHOOL OF HEALTH CARE SCIENCES, USAF
SHEPPARD AIR FORCE BASE, TEXAS

Designed For ATC Course Use

DO NOT USE ON THE JOB

Department of Nursing
School of Health Care Sciences, USAF
Sheppard Air Force Base, Texas 76311

PT 3ABR91431-2-II-12e
July 1975

REHABILITATION RESOURCES
SECTION I

OBJECTIVES

Describe the community resources used in rehabilitating mental health patients.

INTRODUCTION

One of the most important things you as a Psychiatric Ward Specialist can do is to be able to answer questions which patients might have concerning their disposition from the hospital.

This text is designed so that you will go through it step by step. Each frame or step of instruction is designed to teach you a small bit of information. Confirmation of each step is given immediately below the slashes, (//////). You should slide a mark (piece of paper) down the page until the slashes are barely exposed. Read the information and respond as directed. Then, slide the mark downward and confirm your response. Do not proceed until you have responded correctly. If you require assistance, see your instructor.

INFORMATION

Have you ever been in a situation that you did not know how you were going to get out of? If you have, you can imagine how a patient feels when he enters the hospital. He has a tremendous amount of anxiety because he does not know how he will be discharged or what will happen to him when he is discharged.

All patients eventually leave the hospital. Some walk out and some are carried.

When a patient enters the hospital we know there are certain things which will happen to him. We know he will (1) receive treatment, (2) be discharged from the hospital and returned to duty or (3) discharged to civilian life. The goal of the Air Force is to discharge the patients to duty so that he can proceed in his Air Force job effectively.

This supersedes SW 3ALR91431-II-12d, February 1975

When a patient enters the hospital, what two things will always happen to him? (Circle one).

a. Discharged and readmitted
b. Walk out or be carried out
c. Becomes anxious and is discharged
d. Receives treatment and is discharged

//

d

//

If we combine treatment and the preparation for discharge we can put them together under one major purpose of the Air Force Hospital, and this is to rehabilitate the patient. Rehabilitation then can be defined as -- all the treatments aimed to restore the patient to an optimum level of physical and mental functioning.

The ultimate goal of the Air Force Hospital is ________________ of the patient. (Circle one).

a. Discharge
b. Admission
c. Rehabilitation
d. Treatment

//

c

//

We have already discussed earlier in the course, the treatment of a patient; now, we will discuss the way a patient will be discharged. This is part of the rehabilitation process which a patient will receive when he enters the hospital.

When a patient is discharged from the hospital he will usually be sent to one of three places.

He will be (1) discharged to another hospital for further treatment, where he might be discharged from the Air Force and be sent to a VA hospital, (2) discharged to civilian life (medically or administratively), or (3) sent back to his job and remain in the service.

Which of the following are places a patient might be sent when discharged from the Air Force Hospital. (Circle correct answers).

a. VA hospital
b. Back to duty
c. Another hospital
d. Civilian life

//

All are correct.

//

In order to understand what happens to a patient when he is discharged we will use an example of a patient being medically discharged from the hospital. We will follow the steps needed to see what is done to the patient as he proceeds through the hospital for treatment and finally discharged.

Our example will be named MSgt Jones with 18 years of military service who will be admitted to the Mental Health Unit of the hospital. This text will show what things could happen to the patient down the long road to a medical discharge.

The first thing which will happen to our patient is that he will be admitted to the Mental Health Section of the hospital.

ADMISSION TO MENTAL HEALTH SERVICE. This is the initial contact between the specialist and the new patient. The patient has already been admitted to the hospital and now is admitted to the mental health service. This is very important because it is the time when the patient forms many lasting impressions about the staff and the hospital.

Admission to the Mental Health Section of the hospital is the place where rehabilitation actually begins for the psychiatric patient.

Rehabilitation begins for the psychiatric patient when he is admitted to the Hospital. (Circle one).

TRUE or FALSE

//

FALSE - Rehabilitation for a psychiatric patient begins when he comes in contact with the Psychiatric Ward Specialist.

//

The next step in rehabilitation of a patient is diagnostic evaluation.

DIAGNOSTIC EVALUATION. Once the patient is admitted to the ward he will meet his doctor. The doctor, a psychiatrist, will meet with the patient and make a initial evaluation of the mental status of the patient.

Diagnostic evaluation is done by the (Circle one).

a. Psychiatrist
b. Nurse
c. Psychologist

//

a

//

The next step is to begin treatment of the patient.

TREATMENT AND CONSULTATION. The doctor will now prescribe medications and different therapies in order to see how the patient will respond in an effort to help the patient recover. The doctor might send the patient to see other doctors so he could get their impressions of the condition of the patient. The psychologist will also be used here to test the patient's mental abilities.

The person who initiates the treatment is the (Circle your answer).

a. Doctor
b. Nurse
c. Psychologist
d. Consultant

//

a

//

DICTATION OF THE SUMMARY. After the patient has been evaluated thoroughly by the psychiatrist, the psychiatrist will decide what he thinks should be done with the patient. The procedure of evaluating the patient takes from one to six months. The doctor will then assemble all of the patient's inpatient and outpatient records and then dictate the patient's case. This simply consists of dictating all which the psychiatrist deems important to the case of the patient.

The evaluation of the patient takes (Circle your answer).

a. 2 to 3 weeks
b. 1 to 6 weeks
c. 1 to 6 months
d. about 6 days

//

c

//

STENO POOL. After the case has been dictated, it will be sent to be typed in the steno pool. This is simply putting the case in appropriate terms and on the proper forms.

REVIEW BY CHIEF OF DEPARTMENT. In the Mental Health Section of the hospital the Chief of the Service is the Chief Psychiatrist of the Department. He will sign the case and pass it on if the patient is to be medically discharged. If the patient is going back to duty he will send the patient back to duty now. Sometimes, the patient will go back to duty and be administratively discharged under AFM 39-12. Sometimes, he will go back to duty with a limited duty assignment.

Indicate the order the following actions occur to MSgt Jones as he is rehabilitated by the hospital. (Put a 1 before the first item, a 2 before the second, etc. until all items have been ranked).

_____a. Steno Pool
_____b. Treatment and consultation
_____c. Diagnostic evaluation
_____d. Admission to mental health service
_____e. Admission to hospital
_____f. Dictation of summary
_____g. Review by Chief of Department

//

1-e 2-d 3-c 4-b 5-f 6-a 7-g

//

The doctor has decided that our patient, MSgt Jones, is to be Medically Discharged from the Air Force. The next portion of this book will explain how this will be accomplished.

MEDICAL EVALUATION BOARD. If the person is going to be discharged from the service medically, then his case is sent to the central Medical Board (MEB) in the hospital. A MEB is a board of three or more medical officers appointed by orders of the medical treatment facility commander (Hospital Commander). The Hospital Registrar acts as recorder of the board, unless another officer is appointed, and does not have a vote. The medical officers must have a majority vote to approve the board action.

The number of officer on a MEB are (Circle one).

a. 1
b. 3
c. 5
d. 3 or more

//

d

//

The person who selects the members of the MEB is the (Circle one)

a. President
b. Chief of the Dept of Psychiatry
c. Hospital Commander
d. Doctor in charge of patients

//

c

//

The purpose of MEB is to evaluate any patient who is not physically or mentally qualified, or whose physical or mental qualifications for further general military service appears to be in doubt.

The MEB is concerned only with the mental qualifications of a patient. (Choose one).

TRUE or FALSE

//

FALSE - The MEB is concerned with the mental and physical qualification of a patient.

//

The MEB functions as a clinical body acting as consultants, and recommends disposition of the patient to the medical treatment facility commander. The board may recommend return to duty, transfer to a treatment center, discharge from the Air Force, referral to the Physical Evaluation Board (PEB), retention in limited assignment status and continuance of military hospitalization.

The patient's appearance before a MEB does not imply any fault, guilt or impropriety on his part; it is a professional consultation, not a trial. The patient's rights under Article 31 (Fifth Amendment) of the UCMJ, 1951, are not in jeopardy. A patient does not have a right to be represented before a MEB by counsel or to challenge members of the board since Article 31 (Fifth Amendment) are adhered to.

The MEB is a simulated trial where the patient's records are reviewed. (Circle one).

TRUE OR FALSE

//

FALSE - The MEB is not a trial.

//

The MEB will determine if the individual is fit or unfit to perform the duties of his rank. The Board can also make the individual eligible for world wide assignment.

The findings of the board may be that the patient is fit, unfit, mentally competent or incompetent and make recommended findings also for disposition.

The MEB can do which of the following (Circle correct answers).

a. Determine if the individual is mentally competent
b. Set retirement pay for the patient
c. Recommend disposition of patients
d. Determine if the individual is fit for world wide duty.
e. Have patient appear before the board

//

a, c, d

//

A determination concerning mental competency must be included in the MEB report if his competency is in doubt.

The MEB also considers any problem of military medicine and recommends findings to the Hospital Commander.

The following are a list of the recommendations which the Medical Evaluation Board may make.

1. Return to duty: When appropriate, include recommendation for change in physical profile.
2. Reassignment to another hospital for observation, treatment and disposition. This is usually to a hospital with the specialty that the patient needs.
3. Refer to the PEB. This will be discussed in detail later.
4. May recommend action under other directives: This recommendation will cite the governing regulation which covers the situation. For example, a member incapable of duty for reasons such as habits, traits of character, personality defects, unwillingness to perform, mental deficiency, emotional instability, inadaptability, alcholoism, sexual aberration symptoms, and subjective manifestations basically caused by the desire to escape from the service or to evade duties and responsibilities. (AFM 39-12)

The MEB makes these recommendations to the   (Circle one).

a. Doctor
b. Patient
c. Hospital Commander
d. Physical Evaluation Board (PEB)

//

c

//

After a majority of the medical officers approve the board action it then goes to the Medical Treatment Facility Commander for approval or disapproval. The proceedings will then be forwarded as provided in the appropriate regulations.

The point of view of the MEB must be clear. The board evaluates the patient in the military framework, considering his medical capability, for the performance of military duty.

REVIEW BY HOSPITAL COMMANDER. As we mentioned above, the hospital commander sees the case and signs it. The case is shown to the patient here also. Sometimes, after a patient reads his case, he will become extremely upset. The specialist should help the patient by explaining some of the terms the patient might not understand and thus lessen the patient's anxiety.

The person who has the final approval of MEB action is the (Circle one).

a. Doctor
b. Hospital Commander
c. Patient
d. Patient's lawyer

//

b

//

For our purposes MSgt Jones has just been evaluated by the MEB. The Hospital Commander has signed the case and it has been sent to the PEB.

Before we discuss the PEB, let's see how much you know about the MEB. (Circle the correct answer in each of the following):

The MEB is composed of

a. Nurses
b. Hospital Commander and Assistants
c. Medical Officers
d. Officers

//

c

//

The MEB acts as a consultant for the

a. Patient
b. Chairman of the Board
c. Patient's doctor
d. Hospital Commander

///

d

///

The MEB is located

a. At Randolph AFB
b. In Base Legal Office
c. In the hospital
d. At Base Command Post

///

c

///

MSgt Jones' paperwork has been sent to the Informal PEB. Let's see how this board operates.

PHYSICAL EVALUATION BOARD. The PEB relates the member of the Air Force to the civilian environment, considering the degree of damage to his civilian earning capacity. The PEB is a personnel function, and the two boards (MEB and PEB) do not overlap or duplicate each other.

The PEB is a fact finding board composed of three, and only three, voting members who are Senior Officers, Major or above. There are other nonvoting members: a recorder, lawyers, and medical officers as advisors. This board investigates the nature, cause, degree, and probable permanence of illness or injury. (AFM 35-4)

The PEB duplicates the work done by the MEB to see if they have done their job correctly (Circle one).

TRUE OR FALSE

///

FALSE - The MEB and PEB do not overlap

///

The PEB is composed of (Circle one).

a. 3 and only 3 doctors
b. 3 and only 3 Medical Officers
c. 3 and only 3 Senior Officers
d. 3 or more officers

//

c

//

Informal or Medical Board. This board is located at Randolph AFB, Texas. The patient does not appear before this board - only his paperwork. The patient does not have the right to have his council appear before the Informal PEB.

The function of this board is to investigate the disability of the patient as to nature, cause, degree and prognosis. The PEB also sets the amount of disability a person will receive and make recommendations as to how he should be discharged from the service.

The Informal PEB is located (Circle one).

a. At the hospital
b. At Randolph AFB
c. At the Base Command Post
d. At Lackland AFB

//

b

//

The function of the PEB is to decide the (Circle one).

a. Disability of the patient
b. Treatment the patient should receive
c. Cause of the injury or illness
d. Facts behind the illness

//

a, c, d

//

When a patient is discharged by the PEB, there are 5 (five) different ways which they may recommend, depending upon the illness and cause of the illness which the patient has.

FIVE TYPES OF SEPARATIONS.

1. Temporary Disability Retired List (TDRL): A patient who has been put on TDRL must have 30% or more disability and must have received the disability in the line of duty. When a patient receives TDRL he is discharged from the hospital and temporarily retired by official orders. He carries retired identification and has all of the benefits of a retired person; however, he must return to a military hospital in 15 to 18 months to be reevaluated. During the re-evaluation, the disability compensation may be increased or decreased. He can also be subject to return to the service or rehospitalization. After five (5) years, the person is taken off of TDRL and either put back into the service or permanently retired.

Could a person with 15% disability receive a TDRL? (Circle one).

YES or NO

//

No - he must have at least 30% disability.

//

A person put on TDRL must be evaluated once every (Circle one).

a. Week
b. 6 months
c. 15 - 18 months
d. Once a year

//

c

//

2. Permanently Retired: This individual is retired for the rest of his life at the fixed percent of disability regardless of whether his condition improves or grows worse. He or she must receive at least 30% disability, but not more than 75% of his base pay even if the individual is 100% disabled. This disability must be LOD, YES.

COMPUTING RETIRED PAY. There are two formulas for computing disability or retirement pay for disability awarded by the Secretary of the Air Force. The individual may choose whichever formula he wishes.

1. The first formula consists of base pay x 2 1/2% x total years of service.

2. The second consists of base pay x percentage of disability.

If MSgt Jones were to be permanently retired and receive 50% disability what would his retirement pay be using Formula 2. (MSgt Jones Base Pay is $670 per month).

Write answer here ________________________________.

//

$335 per month

//

3. Separation with Severance Pay: The disability may be either permanent or temporary, but must be less than 30% and is nontaxable. Severance Pay consists of two months base pay for each year of active military service up to 24 months or for 12 years. This is paid in a lump sum and is NOT taxable. This too must be in Line of Duty.

If MSgt Jones had 50% disability could he receive severance pay? (Circle one)

YES or NO

//

No - must be less than 30%.

//

If MSgt Jones has 25% disability and is going to receive severance pay, he would not get credit for his total 18 years of military duty. How many years would he get credit for? (Circle one).

a. 16 years
b. 12 years
c. 24 months
d. 25% x 18 months

//////////////////////////////////// //

b

//

4. Separation without Severance Pay: When the individual receives 30% or more disability; when the disability was NOT in Line of Duty such as misconduct, wilful neglect, AWOL, or Existing Prior to Service (EPTS). In this status he would NOT be authorized full pay and privileges by the Air Force.

5. Existing Prior to Service: (EPTS) AFM 39-12. A person may be considered under this if he or she has less than three months active service; also, if this condition is not aggravated by service. On the other hand, a person will be considered for compensation after three months service with a EPTS condition if this was aggravated by the service.

Match the following types of separations with their definitions.

TYPES OF SEPARATIONS	DEFINITIONS
____a. TDRL	1. Fixed disability for life.
____b. Permanent Retired	2. Nontaxable money
____c. Separation with Severance Pay	3. Discharge for injury received while AWOL
____d. Separation without Severance Pay	4. Return to hospital every 15 - 18 months
____e. EPTS	5. Discharge Medically with less than 3 months active duty

//

a-4, b-1, c-2, d-3, e-5

//

If MSgt Jones is not happy with the results of the PEB or the type of disability he is going to receive he can appeal the decision of the PEB. In order to do this, he must write a letter of rebuttal to request a Formal Hearing of the PEB.

FORMAL HEARING. A Formal Hearing must be given an evaluee if he demands it or when directed by directives of Headquarters U.S. Air force. At a Formal Hearing, the evaluee or next of kin may be represented by counsel, make statements, introduce evidence, call witnesses, etc. A full and fair hearing with counsel is his legal right and not a privilege; however, he must be advised of rights under Article 31 (Fifth Amendment). The two Formal Boards are located at Andrews AFB, Washington, D.C., and Lackland AFB, Texas. From here it goes on up the chain of command to the Physical Review Council.

The Formal PEB Board is (Circle one).

a. A result of a rebuttal to the decision of the Informal PEB.
b. Standard operating procedure.

//

a

//

The patient is allowed to be represented by counsel during a Formal PEB. (Circle one).

TRUE or FALSE

//

TRUE

//

As mentioned above, the next step is the Physical Review Council.

PHYSICAL REVIEW COUNCIL. A nonvoting group made up of members of the Deputy Chief of Staff, USAF, and convenes at Headquarters, USAF and reviews all PEB proceedings and rebuttals. Patients do not appear, only records. If the evaluee still does not agree, his case goes on to the Physical Liability Appeal Board. If the PRC, PEB, and evaluee agree, it is forwarded to the Secretary of the Air Force for final decision. Only after he signs the item does the evaluee get a check for medical disability.

PHYSICAL APPEAL BOARD. If the patient does not agree with the decision of the Physical Review Council then he can appeal his case to the Physical Appeal Board. This board is located at Headquarters, USAF. The results here are final and sent to the Secretary of the Air Force.

PHYSICAL DISABILITY PROCESSING. This section is simply in charge of processing the paperwork of the individual for separation from the Air Force.

BASE OF ASSIGNMENT. This is a final stop for the individual. This is where his out processing takes place. Most of the time a person who is medically discharged will be assigned to the hospital. So the patient will simply out-process from the hospital.

Which of the following are a result of a patient appealing the decisions concerning his medical discharge. (Circle correct answers).

a. MEB
b. Formal PEB
c. Informal PEB
d. PRC
e. Physical Appeals Board

//

b, e

//

Who has the final approval of a patient's medical discharge?

a. Physical Review Council
b. Secretary of the Air Force
c. Hospital Commander
d. Physical Appeals Board

//

b

//

SUMMARY:

The MEB is a board of three or more medical officers appointed by orders of the medical treatment facility commander. Any patient who is not physically or mentally qualified or whose physical or mental qualifications for further general military service appears to be in doubt will be referred to it for clinical evaluation. It functions as a clinical body of consultants and makes recommendations to the medical treatment facility commander.

The PEB is a fact finding board. It investigates the nature, cause, degree and probable permanency of the disability in question. It also provides for a full and fair hearing with the Formal and Informal Boards. We listed each other board until it is signed by the Secretary of the Air Force and the compensation or money is only then awarded. The types of separations for disability were discussed and the formulas given for computing retired pay.

When you have completed this portion of the booklet, review all areas, and the instructor will give you the final quiz over this area of instruction.

SECTION II

REHABILITATION RESOURCES IN THE COMMUNITY

You will find that many patients will ask you questions on where they can obtain help, or what will be available to them if they are discharged from the service. Know what is available in the community or be prepared to refer the patient to someone who can tell them the answers to their questions.

VETERANS ADMINISTRATION. (Vocational Rehabilitation). Designed to help Veterans select, train for, and secure work which is in line with his personal goals, interests, and abilities. Veterans are eligible if they have disability, which will entitle them to compensation, if they have been released, retired, or discharged for other than dishonorable reasons, and the V.A. determines that they need training.

Other V.A. benefits include: medical, life insurance, loan benefits, and education for children.

CHAMPUS (Civilian Health and Medical Program for the Uniform Services). CHAMPUS is the outgrowth of the Dependents Medical Care Act of 1956, and it was expanded in 1966, to include more medical services. Active duty and retired personnel and dependents are eligible. Active duty members must have a nonavailability slip from nearest military medical facility. Treatment include medical or surgical conditions mental and emotional disorders and chronic conditions and diseases. Cost is $50 for one member, $100 for family plus 25% of bill for outpatient care and $25 or $1.25 a day whichever is greater for inpatient care.

IN PATIENT SERVICES. In Patient Services, or simply places where mental patients stay 24 hours a day to be tested, consists (in the military) of psychiatric wards located in specific regional hospitals. The Military Mental Health Service performs the services of diagnosing the patient's illness, using consultants in an effort to decide on an approach to meet the patient's needs, evaluating the patient, and finally making a disposition of the patient.

State hospitals also offer inpatient mental health services. These services vary from state to state. State hospitals treat the acute mentally ill; these are usually short term cases. They treat the chronic mentally ill. These are usually long-term patients. The organic brain disorders are also treated in the military. These patients suffer from senility, drug addiction, and alcoholism. Lastly, state hospitals treat the mentally retarded; these patients usually result from birth defects.

The Veterans Hospitals have in patient services. Many of the patients discharged from military mental health hospitals are sent to VA hospitals. These hospitals finish the treatment which the military has started. The VA hospitals can handle long term patients which the military hospitals are unable to do. The VA hospitals also educate the patients in hopes to help them obtain a good job when they are finally discharged.

General hospitals have psychiatric nursing units within them. These patients are usually short term and are treated mentally and physically. These units assist the other services by acting as a consultant where other services can have their patients evaluated.

DAY AND NIGHT CARE CENTERS. The day and night care centers help to integrate mentally ill hospitalized patients back into society. The day patients remain in the center during the day and then go home or to work at night. The night patients work during the day or go home. The patients and their families find it easier to lose their fear of a psychiatric disorder when a patient can return home for part of the day and or weekends. The patients receive various therapies at the center while they are there.

HALF WAY HOUSES. The half-way house is for those patients that are at a standstill. Continued hospitalization fosters dependency, loss of imagination, and loss of potentialities for healthy living. They can maintain an equilibrium in the hospital but not at home. Recognizing the need to escape the immediate stress and strain of the outside world, the half-way house occupies a position half-way between the hospital and home and also half-way between sickness and health. Employment is found before the patient arrives.

PSYCHIATRIC CLINICS. In the military there is a psychiatric clinic available in most hospitals. It is staffed with a psychiatrist, psychologist, social worker, and specialists. This service provides emergency service, family counseling, day care, and possibly in service care when there are no ward facilities available.

ALCOHOLICS ANONYMOUS (AA). This organization is a fellowship of men and women who share their experience and strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. A.A. considers alcoholism as a disease. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership. They are self-supporting through their own contributions.

COMMUNITY MENTAL HEALTH CENTER. The ideal concept is that each center will provide total service to meet the mental health needs of the community. Each center should provide treatment for all ages and all types of mental illness. Plans are under way in all 50 states for small city units rather than large state hospitals.

CONCERN. This group listens to the telephone 24 hours per day. They listen because talking about a problem is helpful and then concern can refer the caller to community agencies that can give them further assistance. Ordinary citizens man the phones, after they have completed the required listening course. Call 723-0821.

RECOVERY INC. This is a national program in 725 locations, with the purpose of preventing relapses in former mental patients and chronicity in nervous patients. Recovery Inc. is a systematic method of self-help after-care for nervous and former mental patients. Each member cooperates with his own personal physician because Recovery Inc. does not advise, counsel, diagnose or treat; it merely attempts to reduce the effects of mental illness by getting the former patient to recognize that his illness is not unique, and that others have his problem.

MARRIAGE COUNSELORS. When either or both spouses enter the doctor's office and declare they are having marital difficulties and wish some assistance, there is little doubt of the diagnosis, and the ensuing action on the part of the physician comes under the heading of marriage counseling. The orginal doctor and patient might elect to work on the problem together with the other spouse, or may be referred to another qualified person such as a psychiatrist, psychologist, social worker, or marriage counseling clinic.

ASSISTING PATIENT IN USE OF RESOURCES

MEB AND PEB BOARDS. As a specialist you can do much to help the patient with the use of the two boards. The specialist must be familiar with the workings of the two boards so he can answer questions which the patient might ask. Knowing where the MEB is located in the hospital is needed so the patient can be directed there easily. The biggest and most important thing the specialist can do is to help the patient ventilate his fears and anxieties about the MEB and PEB.

COMMUNITY RESOURCES. The specialist here needs to know where to find information about the community resources. Show the patient how to look things up in the phone book but remember to let the patient do the work of calling. The specialist can explain the many types of resources available to the patient. The specialist should also discuss the future medical care which the doctor has prescribed for the patient.

SUMMARY

We have seen many varied forms of rehabilitational resources which are available to the patient. Remember, successful rehabilitation depends upon the patient's acceptance of the treatment program as well as the degree of interest and participation placed in rehabilitative experiences.

QUESTIONS

Match each word in Column A with the correct difinition in Column B.

COLUMN A

1. _____ CHAMPUS
2. _____ A.A.
3. _____ Rehabilitation
4. _____ Community Mental Health Center
5. _____ Day Center
6. _____ Psychiatric Clinic
7. _____ Night Center
8. _____ Concern
9. _____ Recovery INC.
10. _____ Marriage Counselors
11. _____ V.A.

COLUMN B

a. Stay in hospital at night, go to work during the day.

b. 723-0821

c. Helps the alcoholic to help himself.

d. Stay in hospital during day, go home at night.

e. Takes care of a broad variety of family difficulties.

f. Provide emergency care.

g. Civilian Health and Medical Program for the Uniformed Services.

h. Serves to meet total needs of the community.

i. Prevent relapse in former mental patients.

j. To help patient become self-reliant and self sustaining in the community.

k. Provides vocational rehabilitation for those who qualify.

REFERENCES

1. Coleman, Abnormal Psychology and Modern Life.
2. McClelland, Textbook for Psychiatric Technicians.
3. Rennie and Woodward, Mental Health in Modern Society.
4. AFM 35-4, Department of the Air Force, Washington D.C.
5. AFM 39-12, Separation for Unsuitability, Misconduct and Resignation.
6. AFM 168-4, Physical Evaluation Board, Ch 16.
7. Action for Mental Health, Joint Commission on Mental Illness and Health.
8. Uniform Code of Military Justice (UCMJ), Department of Defense, Washington, D.C., Article 31 and Article 121.
9. Manual for Court Martial (MCM), Department of Defense, Washington, D.C., PP 200-204, Insanity.